DOCUMENT RESUME

ED 088 251 EC 061 309

TITLE	A Study of Georgia's Services for the Mentally Retarded, Volume I.
INSTITUTION	Atlanta Association for Retarded Children, Inc., Decatur, Ga.
PUB DATE	Jan 72
NOTE	122p.; For Volume II see EC 061310
EDRS PRICE	MF-$0.75 HC-$5.40
DESCRIPTORS	Community Role; *Exceptional Child Services; *Mentally Handicapped; *Normalization (Handicapped); Program Evaluation; Program Planning; *State Surveys
IDENTIFIERS	*Georgia

ABSTRACT

Presented is the first of two volumes reporting on a 2-year study of Georgia's services to the mentally retarded by the Atlanta Association for Retarded Children (AARC). Discussed in the section on organization, philosophy and methodology is the concept of normalization as an underlying philosophy of AARC. Briefly described are model programs observed in Denmark, Sweden, Belgium, the Netherlands, England, Wisconsin, and Connecticut. A model comprehensive service system and existing community services are both described in terms of the following areas: diagnosis and evaluation, family services, mental and physical health services, education and training services, work training, economic-legal supportive services, recreation services, religious training, transportation, and residential services. Noted is visitation of existing residential services by AARC staff members to determine current status of services. Detailed are evaluations of three special purpose residential facilities and three multipurpose residential facilities. Recommendations are given in the areas of comprehensive mental retardation programs, specialized residential programs, improvement of existing residential facilities, and program planning. Examples of recommendations are funding priority for community based small group homes and admission to state institutions only for retardates whose needs cannot be met in the community. Among appendixes are the text of a Declaration of Rights, a listing of reference materials, the questionnaire used in the residential study, and a chart of the model comprehensive service system. (DB)

A STUDY OF GEORGIA'S SERVICES FOR THE MENTALLY RETARDED

BY

THE ATLANTA ASSOCIATION FOR RETARDED CHILDREN, INC.

VOLUME I

January 1972

PROJECT PARTICIPANTS

PROJECT STAFF, Atlanta Association for Retarded Children

G. Thomas Graf, AARC Executive Director and Project Coordinator
Jane S. Query, Director of Project Research
Alice W. Thrasher, Director of Community Education
Melvin E. Kaufman, Ph.D., Project Consultant
Norman L. Meyers, Director of Program Services
Patricia S. Powell, Psychologist
Susan P. TeStrake, Social Worker
Mary C. Townley, Project Secretary

ADVISORY COMMITTEES*

Board Residential Advisory Committee

John D. Webster, Ed.D., Chairman
Robert Freeman
Benjamin Hudson, Ph.D.
Janice Thomas
Thomas L. Tidmore, Jr., M.D.

Professional Advisory Committee

Maurice Flagg, formerly with the President's Committee on Mental Retardation
Kermit Harrington, National Association for Retarded Children
Gene Patterson, National Association for Retarded Children
Jack Schmitt, Community Council of the Atlanta Area
Webb Spraetz, Georgia Association for Retarded Children

Civic and Service Advisory Committee

Fred L. Parks, Civitans, Governor Georgia District North
Ralph Britt, Civitans, Governor Georgia District South
Jerry Peters, Georgia Federation of Women's Clubs
Barbara Hardin, Jaycettes
Brooks Cagle, Jaycees

PARTICIPATING GROUPS

Atlanta Association for Retarded Children
Community Council of the Atlanta Area
Georgia Association for Retarded Children
National Association for Retarded Children
President's Committee on Mental Retardation
Members of: Ad Club II, Georgia Jaycees, Jaycettes, Civitans, Women's Clubs, etc.

CONSULTANTS*

Gunnar Dybwad, Ph.D., Professor of Human Development, Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University
Edgar Johnstone, Consultant for the President's Committee on Mental Retardation
Francis Kelley, Superintendent, State Training School, Mansfield Depot, Connecticut
Gene Patterson, Consultant in Program Services, National Association for Retarded Children
Charles Rogers, Community Council of the Atlanta Area
Jack Schmitt, Community Council of the Atlanta Area
John D. Webster, Ed.D., Southern Regional Education Board
Wolf Wolfensberger, Ph.D., Retardation Research Scientist, Nebraska Psychiatric Institute

AARC-GARC REGIONAL CHAIRMEN FOR PUBLIC INFORMATION CAMPAIGN

Albany, Georgia - Ethel Lowe
Atlanta, Georgia - Katie Bishop
Mary Lee Brookshire
Annie Joe Denney
Margie Anna Gatlin
J. C. Latham
Eleanor Swann
Augusta, Georgia - Katherine Berg
Columbus, Georgia - Jo Walton
Macon, Georgia - Nora Howard
Rome, Georgia - Mildred Knight
Savannah, Georgia - Jack Blackstone, Ph.D.

*The Study was conducted with consultation and advice from members of the various advisory committees and the consultants listed. However, the views expressed and conclusions reached are solely those of the Atlanta Association for Retarded Children.

TABLE OF CONTENTS

Acknowledgements

Organization, Philosophy and Methodology of Study
Introduction 1
Objectives of the Study 2
Underlying Philosophy 4
Organization and Methods 6

Study Visits to Model Systems 11
Denmark 11
Sweden 12
Belgium, the Netherlands, England 13
Wisconsin 15
Connecticut 16

The Model Comprehensive Service System 19
Diagnosis and Evaluation Services 21
Family Services 22
Mental and Physical Health Services 22
Education and Training Services 23
Work Training 25
Economic-Legal Supportive Services 25
Recreation Services 26
Religious Training 27
Transportation 27
Residential Services 28

Existing Community Services in Georgia 31

Status of Existing Residential Services in Georgia . . . 36

Special Purpose Residential Facilities . . . . . .
Athens Unit, Georgia Retardation Center 39
Georgia Regional Hospital at Atlanta 45
Southwestern State Hospital 51

Multipurpose Residential Facilities
Central State Hospital 59
Georgia Retardation Center 67
Gracewood State School and Hospital 76

Recommendations for Action 85

Appendices
A-Declaration of Rights 100
B-Reference Materials 102
C-Questionnaire 104
E-Model Service System 112
F-Classification 114
G-Staff Ratios 115
H-Cost of Services 116

ACKNOWLEDGEMENTS

The Atlanta Association for Retarded Children extends its thanks to Dr. Addison Duval, Director of the Division of Mental Health, and his staff members for their cooperation in making this study possible. Special recognition is due the superintendents and staff of the six institutions visited for the help given in preparing statistical data, conducting tours of the programs, and furnishing questionnaire information.

Dr. Tom McConnell, Coordinator of Community Mental Retardation Programs, Community Services Branch of the Division of Mental Health, provided much valuable information, and Ann Johnson of Bio-Statistics worked with us in providing computer data on institution residents.

The President's Committee on Mental Retardation through Mr. Maurice Flagg and Ruder and Finn Agency, furnished valuable advice in planning our public information campaign. John Stevens, Ober Tyus, Chuck Kelly, The Darby Printing Company, Typography Shop and General Lithography Company gave generously of their time and professional talents in producing our study brochure, "New Hope for Dignity." Coach Bobby Dodd, Georgia Tech Athletic Director, has been most helpful in several phases of the public information campaign. Our thanks go to the representatives of all the various communication media for help in presenting our study to the public. In particular, Channel 5, WAGA, and its staff members are due thanks for their interest and support expressed in the production of their documentary program on mental retardation.

For their interest and efforts on behalf of our study recommendations, we wish to thank Senator Bobby Rowan and the other members of the Senate Committee on Institutions and Mental Health: Senators Sam W. Doss, Jr., Frank Eldridge, Jr., Michael N. Herndon and Culver Kidd. Also, Representatives Clarence R. Vaughn, Jr. and Bill Noble, two legislators who worked for the implementation of the study, are to be commended.

For their financial support of our organization and our programs, we owe thanks to the citizens, civic groups and business firms of Metropolitan Atlanta. For special financial support of the Residential Study Project, we thank Mr. A. B. Padgett of the Trust Company of Georgia, the English Foundation, and Mr. Frank Robinson and the Metropolitan Foundation.

The Community Council of the Atlanta Area is due thanks for the services of Jack Schmitt and Charles Rogers in collecting and interpreting statistical data, and in the early planning of the project.

Our special thanks go to Dr. John Webster, at that time Associate Director, Commission on Mental Illness and Retardation, Southern Regional Education Board, who donated many hours as chairman of our study committee, and as a member of our European visit team. We are grateful to the many people in Denmark, Sweden, Holland, Belgium and England who showed us their programs, and made our visits so pleasant. The staff members of facilities in Wisconsin and Connecticut, also, spent much time with us and furnished valuable information.

To all the many people, agencies, and groups who gave of their time and service to help in all phases of the study, we are especially indebted.

Organization, Philosophy and Methodology of the Study

INTRODUCTION

Throughout the history of the Atlanta Association for Retarded Children (AARC) its primary concern has been the welfare of retarded persons. The Association expressed this concern through its activities, either by providing direct services in areas of need or by obtaining these services from appropriate community agencies. It maintained that retarded citizens should rightfully have all the services available to the normal citizen in the community and that these services should meet prevailing community standards, both as to quality and quantity.

The AARC has experienced a pattern of growth historically parallel to that of many other such groups. The Atlanta Association was organized by parents and friends of the retarded because there were no services available for their children. The first service goals were appropriate education and training programs. When these seemed to be unavailable in the community, they were provided by the AARC itself through the initiation of a small day school for trainable and educable children. As needs changed, workshops, activity centers and summer camp programs began to evolve. The Association soon realized that it must look to the larger community for these services since it was neither practical nor indeed possible for parent groups to provide financial support for all the programs that all retarded citizens might need for a lifetime.

Consequently, program emphasis in recent years has changed from that of providing direct services to obtaining them from tax-based public agencies. The Association views its function as that of a social change agent. By identifying mental retardation needs and eliciting the interest and support of the community, it hopes to mobilize state and local resources to meet these needs. Where past efforts have been well-organized and united in purpose, they have been quite successful. In the last four years, the passage of a mandatory education bill for exceptional children resulted in great increases in special education classes. The Association stimulated the establishment of day training centers funded by state and local health departments. Funds for two new workshops in the metropolitan Atlanta area were appropriated, largely as the result of social action campaigns by the Atlanta unit and other local units of the Georgia Association for Retarded Children (GARC).

At this point in time, the metropolitan Atlanta area has begun to develop many elements of the "continuum of care" described by the President's Panel on Mental Retardation in its 1962 publication "National Action to Combat Mental Retardation." Very little study or consideration has been given however to the element of residential service.

In recent years, there has been a wave of nationwide concern expressed relating to the overcrowded, understaffed public institutions serving the retarded in many of our states. Such organizations as the President's Committee on Mental Retardation, National Association for Retarded Children, and the American Association on Mental Deficiency have made recommendations

for improving residential services, both in concept and operation.

The AARC felt that it should inform itself concerning residential services in Georgia. Most of the area's retarded citizens in need of residential service were still being served in two large, overcrowded, multi-purpose institutions over one hundred miles from Atlanta. There were many questions that needed answers. How well were Georgia's state residential facilities meeting the needs of their retarded residents? Were their services developing in ways that reflected modern concepts of care? Did residential services coordinate well with developing community services? Were Georgia's limited funds being used in ways that best met the needs of retarded citizens? These considerations influenced the AARC to undertake the present study. It is a natural outgrowth of our historic and philosophic roots.

OBJECTIVES OF THE STUDY

Although the primary goal of the study was the assessment of residential services for Georgia's mentally retarded, it was apparent from the beginning that such programs must be considered within the framework of all services available in the community. To a great extent, the number of institution residents and applicants on the waiting list depends not only on the space and programs available in institutions but also on the services provided the retarded person in his home community. In rural areas and small towns, parents must often look to the institution as their only resource for education, training, or specialized treatment services for their child. In areas where more training and supportive services are available, more parents are able to keep their children at home. The study objective can be stated then as "to assess the current status of residential services in Georgia within the continuum of care for the mentally retarded." No attempt has been made, however, to produce a "Master Plan" for Georgia. The recommendations proposed seek only to promote services consistent with the most up-to-date and humane concepts of care.

The original target area for concern was that of Greater Atlanta. The scope of the project quickly broadened because of the difficulty of treating the area separately from the state as a whole. In general, state institutions serve the entire state. Even the newly constructed regional hospitals do not admit exclusively on a regional basis to their mental retardation units; they have special programs which affect admission policies. In addition, recommendations made by the study committee would if implemented affect services on a statewide basis. With the support of the Georgia Association for Retarded Children (GARC) Board of Directors, the study became statewide in scope.

The project deals with the following fundamental questions concerning services for the mentally retarded:

--Does the residential institution system stress efficient patient management resulting in restriction of normal growth and development?

--Does the existence of the long-established institutional system make difficult new programs and activities?

--Is the Georgia taxpayer getting his dollars worth in mental retardation programs?

--Why is the percent of need now met in residential care almost double that of public school Special Education and five times that of community training programs?

--Are certain inequities apparent based on race, geographic area or socioeconomic considerations? In other words, do all families receive equal treatment?

--Why is there such major per diem cost variance in Georgia's facilities? Does this reflect lack of uniformity in the education, treatment and rehabilitation services offered by the different facilities?

--How is it determined where a retardate receives residential services?

In order to answer these questions, the original project proposal delineated certain areas of action, and set down these objectives;

--To conduct a study into the quality and quantity of residential services offered the retarded of Georgia.

--To make recommendations, based on the study, concerning residential services and other areas of comprehensive community services.

--To prepare and disseminate information throughout the life of the project which would inform the people of Georgia as broadly as possible so that the recommendations could be effectively implemented.

--To study and obtain documentation of other programs both nationally and internationally which have effectively mobilized and used community action processes for better programs and services for the mentally retarded.

--To establish processes and methods of action, in conjunction with national, state and local agencies, which will effectively implement the recommendations.

--To follow up the original study, after a period of two years, with an assessment of the quality and quantity of residential services at that time.

In an attempt to meet the objectives and answer the questions posed above, the body of the report will deal with a review of present residential

services, recommendations for near term improvements as well as for long term comprehensive programs. The major underlying philosophy which forms the basis for evaluation of existing programs is expressed in the principle of "normalization." It would be impossible to interpret our findings in any meaningful way without first discussing this principle.

UNDERLYING PHILOSOPHY OF MODERN MENTAL RETARDATION PROGRAMMING

The concept of "normalization" as exemplified today in modern and humane programs for the retarded represents the most far-reaching change in many years in the philosophy of care for the handicapped.

Normalization has been described by Nirje in quite simple and understandable terms as follows: "to let the mentally retarded person obtain an existence as close to normal as possible." It can be applied to handicapped people of all levels of functioning, and can be the yardstick by which all services -- medical, educational, social and legislative -- can be measured. It is an idea of beautiful simplicity and easy application. As much as possible, retarded persons should be treated like ordinary persons of their age are treated in the community. Every effort should be made to change those aspects of behavior, appearance and life style which make the retarded person different from the average citizen of the same age. Culturally appropriate behavior should be fostered; abilities and human qualities developed as fully as possible.

What does "normalization" mean to the retarded person in terms of services and facilities?

NORMALIZATION means a normal rhythm of the day. It means getting up and going to bed at approximately the same time as others of your age group -- not getting up early and going to bed early to suit the artificial life setting of a hospital environment. It means getting dressed in your own clothes, not wearing hospital gowns or undesignated state-issue clothing, or going barefoot when others wear shoes. It means feeding yourself, if possible, eating in small groups in a pleasant setting -- not being hastily spoon fed by harried and overworked attendants.

NORMALIZATION also connotes a normal rhythm of life. Most people live in one place, go to school or work in another, entertain themselves in various places in the community, receive their medical and dental services at community facilities. When all these activities take place under one roof, an "institution" is created. Effective participation and interaction with the community are eliminated.

NORMALIZATION means maintaining a normal rhythm of the year with holidays, weekend activities, vacations, birthday celebrations, etc. It does not mean spending day after day in one ward in hopeless inactivity with little to break the deadly monotony of existence. Even normal persons would find it hard to maintain any integrity of character, personality, or spirit in such a way of life.

NORMALIZATION means undergoing normal developmental experiences of the life cycle. For young children, it envisions a secure, stimulating atmosphere, and pleasant contacts with a small number of understanding adults. For school age youngsters, it means relationships with peers, with adults, and a widening contact with the community. It follows then that mentally retarded children should not live in the same institution units as retarded adults. The practice of assigning care of mentally retarded children to retarded adults in institutions is common, but it is not "normal." Normally young people and adults gain independence and leave the family home. It follows then that mentally retarded adolescents and adults should not ordinarily live in the same setting as retarded children since it emphasizes their dependency and their differences from others. As retarded people become older, they should remain in a familiar and comfortable setting, if possible.

NORMALIZATION means having your own preferences, desires and wishes considered and respected. It means living in a heterosexual world. It means having a measure of economic security, with some pocket money of your own. It does not mean having all decisions made for you, or having relations and contacts with other people outside your ward severely limited.

Standards of physical facilities for retarded citizens, such as hospitals, schools, group homes, etc. should be the same as those applied to facilities for ordinary citizens. It is ironically acknowledged among professionals working in mental retardation that when any facility or item no longer has value to the normal society, it is then "bequeathed" to retarded persons. The retarded get the abandoned school, the discontinued facility, the outdated books and the worn clothing and toys. In a neighboring state within the last few years an abandoned prison facility considered unsuitable for criminals was converted for use as a residence for the mentally retarded!

Perhaps to some people, the "normalization" concept may seem an artificial device when applied to some severely damaged children. Such children require a great many services and by the nature of their disability are destined for prolonged dependency. No matter how handicapped, however, the retarded person is not a subhuman animal but a human being who possesses legal rights and who deserves respect and dignity. He should be able to exercise these rights insofar as possible, and have opportunities to reach his full potential. This is not an impossible dream from some ivory tower. It has been implemented in the Scandinavian countries in their excellent service systems and is beginning to be incorporated in some state programs as well. In Sweden, it is expressed in laws organizing the system and setting forth the rights and services due the mentally retarded.

In June 1968 the International League of Societies for the Mentally Handicapped published a report entitled "Legislative Aspects of Mental Retardation." This report placed special emphasis on maintaining contact between the retarded and the community, effecting as nearly as possible complete integration into society. In October 1968 this same society adopted a very concise statement of the principles of normalization.

This document details the principles clearly and is reproduced in full in Apendix A.

The concept of "normalization" implies that the community will maintain the mentally retarded in as normal a situation as possible. Although this is a simple idea and seemingly self-evident, a brief visit to any large institution will show that the residents have essentially "abnormal" life styles. Isolated from the community both physically and socially, many institutions find it almost impossible to provide "normal" living experiences for their residents. For this reason, normalization can best be realized by alternative services based in the community. Fortunately in many cases such alternatives prove to be less expensive.

THE RESIDENTIAL STUDY: ORGANIZATION AND METHODS

The original concept of the Residential Study was developed by Dr. John Webster, AARC Board Member, and Mr. G. Thomas Graf, AARC Executive Director. The idea was discussed further with individual board members for their reactions, and a short outline of the proposal was developed. This was presented to the January 1970 board meeting for the consideration of the full board. At that time, the board accepted the general concept, and asked the Budget and Planning Committee to make a further, more detailed study of the proposal.

At this same period, Mr. Maurice Flagg, then a staff member of the President's Committee on Mental Retardation (PCMR), met with AARC staff members during an Atlanta visit. He told the group that as a result of a survey conducted by PCMR, the AARC had been identified as an organization successful in social action and public information activities. PCMR was interested in documenting a social action process, with a view to disseminating information about methods and procedures to other groups. There was an area of common interest between the AARC Residential Study which included plans for a social action campaign, and the special purposes of the PCMR. Negotiations were initiated between the two groups for mutual assistance to these ends. It was agreed that PCMR would assist the AARC with their public information plan and give consultative assistance. In addition, they would monitor the project as it developed.

The proposal was introduced at the January board meeting of the Georgia Association for Retarded Children (GARC) and approved by this group in principle. It was emphasized to the Board that any findings and recommendations of the study would be statewide in scope and require the help of all state units for implementation.

The fully developed proposal was presented to the Budget and Planning Committee and then to the AARC Board as a whole. It was approved by both groups in February 1970. The formal support of National Association for Retarded Children (NARC), PCMR and the Community Council of the Atlanta Area (CCAA) was solicited and received in February and March 1970.

The budgeting of funds to carry out the Residential Study covered such items as reassignments of staff time, and prorated allotments of the ordinary ongoing expenses of the AARC; the total cost was estimated at $87,160.00. The only extraordinary items budgeted were additional travel allowances, consultant fees and expenses related to the production and publication of the report itself. Mr. A. B. Padgett, of the Trust Company of Georgia, was instrumental in obtaining contributions from the English Foundation of $9,000.00 which partially offset the cost of site visit travel and the salary of the Community Education Director. The Metropolitan Foundation contributed $5,000.00 for public education materials to be used in the implementation phase. The CCAA, GARC and NARC contributed staff time to the project. The PCMR provided the services of a public relations firm, Ruder and Finn, who outlined a public relations plan for the second and third phase, concerned with obtaining the cooperation of public officials and implementing the study. Primarily, however, the funding of the study was supplied from the resources of the AARC.

As the first implementation action, the board appointed a Residential Advisory Committee. This Committee instructed Mr. Graf as Project Director to organize a Professional Advisory Committee, a Civic and Service Advisory Committee and to make permanent staff assignments to the project. The Professional Advisory Committee was set up consisting of representatives from NARC, GARC, CCAA, and PCMR. These groups were asked to sanction and involve themselves in the study. Mr. Graf made personal contact with representatives of the Civitan Club, Jaycees, Jaycettes and Georgia Federation of Women's Clubs and gave presentations at group meetings of the various organizations. All of these groups voted their support, and appointed liaison persons from their membership.

The study proposal outlined four phases of activity: planning, inquiry, implementation and follow-up. Phase One and Two have been completed and are described in detail below. Phases Three and Four which concern future activities are outlined.

Phase One - Planning. January 1, 1970 to July 1, 1970

In addition to the planning and organization activities already described, staff assignments to the project were made and their duties and time involvement allotted to the various phases. In addition to Mr. Graf, Mr. Norman Meyers, Mrs. Patricia Powell, Mrs. Jane Query, and Mrs. Susan TeStrake received assignments. Arrangements were made to provide the necessary secretarial services.

A series of discussions were initiated with Dr. Addison Duval, Director of the Division of Mental Health of the State Department of Public Health. AARC staff members met with Dr. Duval and his staff on two occasions. The objectives of the study were thoroughly explored, and the cooperation and help of the Division in accomplishing them were solicited. After studying the request, and discussing it with institution staff members and other administrators of the Health Department, Dr. Duval agreed to give the cooperation of his department. Mr. Graf and Mr. Spraetz made preliminary visits at each of the institutions to inform the superintendents concerning the study, and request their support.

Special materials relevant to the study were obtained for the information of the staff and a review of the literature begun. (Appendix B) The information and data collected have been retained and will be combined with new information as it becomes available. Hopefully, a continuing service can be developed.

As part of the first planning activity, arrangements were made for Dr. Webster, representing the Residential Advisory Committee, and Mr. Graf as Project Director to visit mental retardation facilities in England, Denmark, Belgium and Sweden. Mrs. Ouery was scheduled to visit facilities in Connecticut and Mr. Meyers in Wisconsin. These sites were selected as representative of the best programs offered in this country and in Europe. The European visit was made in June and the Connecticut and Wisconsin visits in July. These visits and the impressions gained from them are described in detail in another section of the report. Questionnaire forms covering various facets of the service delivery systems were prepared.

Phase Two - Study and Recommendations. July 1, 1970 to April 1, 1971.

A study was made by the staff members of a number of different accreditation standards, institutional evaluations done by other groups, and policy statements and declarations promulgated by various organizations concerned with the mentally retarded. (Appendix B) In a series of meetings, a questionnaire was developed for team use in site visits by members of the study group. (Appendix C) Arrangements were made with the superintendents of the several institutions for the site visits and the dates selected. Six institutions were visited by staff teams during the month of November 1970.

Georgia Retardation Center, Atlanta, on November 5 and 6
Georgia Regional Hospital at Atlanta, on November 9
Gracewood State School and Hospital, Gracewood, on November 16 and 17
Central State Hospital, Milledgeville, on November 19 and 20
Georgia Retardation Center at Athens, on November 23
Southwestern State Hospital, Thomasville, on November 30 and December 1

Each staff member was assigned certain areas of responsibility which remained constant during the study so that a basis for comparison might develop. The visits, most of which occupied two days, consisted of an meeting with the superintendent, separate interviews with different department heads, a general tour of the institution, and visits to specific programs by assigned staff members. Each institution was requested to furnish statistical information in addition to the questionnaire information. Copies of the questionnaire were sent to the superintendents in advance of the team's visits. Without exception, the superintendents and their staff members were most helpful in preparing the information, answering questions, and showing the team their programs.

At the conclusion of the site visits, the data collected was organized and charted where possible. Staff members shared their impressions and information and made tentative recommendations for discussion by the Residential Advisory Committee.

Other statistical data was requested from the records of the State Department of Public Health. This included detailed waiting list information as well as additional data about institution residents. After all possible information was compiled, the actual writing of the report began.

The working draft of the report and its recommendations was presented to the Residential Advisory Committee members for their comments and suggestions. Changes agreed upon were incorporated into a revised version of the report. In a similar manner, the working draft of the report and recommendations were submitted to the AARC Board members for their approval.

During the active periods of the study the staff was fortunate in obtaining consultation and advice from a number of knowledgeable and outstanding people in the field. Mr. Gene Patterson, Consultant in Program Services, NARC, spent two days with the staff during the planning period, and gave helpful advice, materials and resources. Dr. Gunnar Dybwad, Professor of Human Development at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, visited Atlanta in February 1970 as the principal speaker at the AARC annual meeting. In a meeting with the staff, he gave valuable suggestions and help in planning. Mr. Jack Schmitt of CCAA, worked with the project staff in the early planning phase and together with Mr. Charles Rogers, also of CCAA, assisted the staff in the collection and interpretation of statistics. Dr. Wolf Wolfensberger, Retardation Research Scientist from the Nebraska Psychiatric Institute, made a dynamic public presentation of the normalization principle at the January 1971 AARC annual meeting. He gave additional suggestions as to organizing the report recommendations. Mr. Edgar Johnstone, Consultant for the PCMR, visited Atlanta on several occasions during the study as a liaison person and gave the staff helpful advice. In April 1971 Mr. Francis Kelly, Superintendent of the State Training School, Mansfield Depot, Connecticut, talked with the membership on "Group Homes" as a way of delivering residential services, and provided useful statistics as to the cost of such services. During the actual writing of the study report, Dr. Melvin Kaufman, Professor of Special Education, Georgia State University, acted as consultant to the staff.

Phase Three - Implementation. April 1, 1971 to January 1, 1972.

In May, a series of regional meetings were held in seven different locations in the state. The study recommendations were presented at hearings to which GARC members, professional groups, institution staff, civic groups, and the public at large were invited. The reactions of these groups to the proposals were noted. (Further reports of these meetings will be given in Volume II.) At the conclusion of the hearings, the findings were reported to the Residential Committee and the Board. The final form of the recommendations was drafted and incorporated into the report.

Overlapping Phase Two and Phase Three, a public information campaign was developed and continued. In December 1970, Mrs. Alice Thrasher was employed as Community Education Director, to formulate plans for widespread dissemination of information about the study, its recommendations and

findings. At a press conference held at the State Capitol Building on February 17, 1971, a formal announcement of the study was made by Coach Bobby Dodd to a group including state legislators, interested citizens and representatives of the newspapers and TV stations. Mrs. Jimmy Carter, wife of Georgia's Governor, attended the press conference. Mrs. Carter, as a result of her interest in mental health and mental retardation problems, has been active in these fields since her husband's inauguration. Staff members have participated in interviews on TV and radio in which the residential project, as well as other aspects of mental retardation programming, was discussed. Statewide coverage in local newspapers has been solicited and obtained.

A statewide action committee, consisting of representatives of ARC units, civic and professional groups, etc. has been formed. An organizational and planning meeting was held in Atlanta on November 19, 1971. Materials which had been developed were distributed at this time, such as brochures, sample legislation, lists of legislators, slide series and scripts.

A local television station is preparing a thirty minute documentary on mental retardation which will be shown in Atlanta before the legislature meets and will be available for statewide presentation. In addition, two thirty-second TV spots presenting "normalization" are being produced and will also be available statewide.

During the remainder of this phase, every effort will be made to mobilize the general public to support legislative action and funding to improve services for the mentally retarded. The civic and service groups involved in the project will be asked to be active in this respect. The communication media will be used to the fullest extent possible through press releases, articles and interviews. The 1972 Georgia General Assembly will be asked to begin an implementation of the recommendations through legislative action and funding.

Phase Four - Follow-Up and Evaluation.

The effectiveness of the study can be judged only by the actual improvements made in residential and community services for the mentally retarded. These improvements will depend on a number of things -- legislation enacted, funds appropriated, priorities changed, changes in the delivery of services. A number of years will be required for complete implementation. However, in a period of two years following phase three, changes in services should begin to be visible if AARC efforts are successful. At the end of this period, a reassessment of residential and community services is planned.

Study Visits to Model Systems

STUDY VISITS TO MODEL SYSTEMS

During the summer of 1970, the Residential Study staff members and one Residential Committee member made visits to several European countries and two states in this country to see at first hand some of the better service programs for the mentally retarded. The organization of these systems and some of their outstanding features will be discussed.

Denmark

Denmark, a small densely populated country with extensive welfare and social services, has outstanding programs for the mentally retarded. Under the 1959 Act Concerning the Care of the Mentally Retarded, a Mental Retardation Service has been set up as a semi-independent organization under the Ministry of Social Affairs. The service system is divided into twelve regions, each being administered from a regional center. Each center is responsible for a complete array of services, both residential and community based, for all retardates in the area. This service is entirely financed by the national government.

The visiting team was especially impressed by the way in which the "normalization principle" is exemplified in all phases of the Danish programs. The facilities visited are located in Region I, the Copenhagen area. The regional headquarters are centered at Vangede Children's Hospital which serves 325 moderately, severely and profoundly retarded children whose special problems prevent their living at home. Approximately 35 children are treated on an outpatient basis. This attractive modern facility contains small living units with sleeping areas for one, two and four persons in homelike surroundings. Each resident is treated as an individual, with his own personal possessions, privacy, and individualized program. A comprehensive program of education, physical therapy and medical treatment is offered. In addition to in-patient services, the center administers seven day kindergartens, two training schools for moderately retarded, five schools for mildly retarded children, two special treatment homes, one residential boarding home and three recreation and holiday homes.

Nearby is Lillemosegard, serving three hundred adults in need of medical and nursing care. Like Vangede, residents have small individualized rooms rather than large dormitories. A complete program of therapy and educational services is offered. A workshop is located on the grounds. Community programs offered for adults are also operated from this institution, as follows: one local institution, four relief homes, eight sheltered workshops, five hostels and one foster home.

Outstanding features of the Danish system are:

--Excellent training of direct care manpower. The Central Academy, administered by the National Agency, conducts a three year training course to prepare workers for both community and residential programs. This

training plus a good salary schedule for direct care personnel results in low turnover rates, and an extremely high quality of direct care.

--Administrative efficiency resulting from concentrating all services in one agency. Parents can find all the help they need for the lifetime of the retarded child in one central location. Duplication of effort is avoided.

--The excellent programs themselves which promote normalization, and preserve the human dignity and human rights of the retarded individual.

Sweden

Sweden, although it has rugged terrain, is well developed agriculturally and industrially. In comparison to Denmark, it is sparsely populated. Sweden is known for its advanced social legislation and extensive social welfare services.

The delivery of service to the mentally retarded in Sweden varies from the Danish system in terms of organization and administrative structure, but is also based on the "normalization" principle. In 1968, the Provisions for Mentally Retarded Persons Act was passed, setting up the legislative and financial structure of the Swedish service system. Health services are organized at three political and geographic levels: the county level, covering between two and three hundred thousand people; the regional level, covering one million people; and the total national level.

At the county level, a Board for Provisions and Services for the mentally retarded has the responsibility for planning and implementation of all necessary services. Board members include the director of schools for the mentally retarded, a director of care, a medical director, and representatives of parent groups. County tax funds support the local projects. At the regional levels, hospitals are provided to meet needs for specialized treatment not available at county levels, such as services for the multihandicapped, physically handicapped, epileptics, blind, deaf and those with behavior problems. The National Board has the responsibility for implementing the Act, and offering supervision, consultation and advice.

The Hagaby Village for Adults and a parent-sponsored community workshop were visited in Uppsala. The village was made up of homes such as one might find in an American suburb, with private bedrooms, living rooms and dining rooms decorated in an attractive and comfortable manner. All the residents were engaged in some type of meaningful activity such as a workshop or occupational training program. The workshop itself, serving the moderately retarded, was modern in every respect and contained heavy industrial equipment requiring sophisticated work procedures.

Also visited in Uppsala was the Stiftelsen Ala Workshop, operated by the Swedish National Parents Association in cooperation with the Health and Welfare Ministry and the University of Uppsala. This workshop served

approximately sixty-seven moderately retarded persons. This workshop was unique in Sweden in that it was run by a private agency. Like the Village Workshop, intensive use was made of heavy industrial equipment rather than small subcontract jobs found in American workshops. A research project concerned with job aptitude and evaluation was being conducted.

The most outstanding features of the Swedish system are:

--The Swedish program's firm base on legislation insuring the rights of the retarded.

--The "normalization" principle as expressed in all programs.

--The excellent highly-effective programs themselves.

Belgium, The Netherlands, England

Belgium, the Netherlands and England are similar in that they are relatively small, densely populated and highly industrialized. The populations of these countries are fairly homogeneous, although Belgium has two major language groups. In England, there is an extensive national health program which furnishes many services to the retarded, while in Belgium the majority of services are provided by private foundations and church organizations with some government funding. Belgium is in the process of developing its program, and needs more special education services. Recently the Netherlands has increased its publicly supported programs. Visits in Belgium, Holland and England were limited to studying individual program components rather than an examination of an entire system and organization of program delivery. Actual site visits were limited to specific facilities and programs that were considered unique and innovative in themselves.

In Belgium, the team visited the Virgo Immaculata, a small institution for women in Lennik, which is operated by a Franciscan Order of Nuns. Nine nuns trained in special education and a part-time pediatrician comprised the staff of this sixty-eight capacity home for moderately retarded women. Included in the program was a workshop where the women packaged soup for a commercial firm and engaged in embroidery, weaving and the production of lace sold in local stores. In Belgium the majority of institutions and programs, aside from those under special education auspices, are operated by church groups and private institutions with some funding from the government. Adult institutions are generally segregated by sex, which is quite a vivid contrast with the Scandinavian normalization concept and programs. This institution was clean and attractive and the residents were busily engaged in meaningful work.

The Dutch programs for the retarded were quite similar to the organizational pattern found in Belgium. The majority of institutions and community programs were operated by large private foundations and church organizations with most of the funding coming from the government. Dr. van Londen, Director of the Division of Mental Health in the Hague, served as the guide for the Dr. Professor N. Spreyer Workshop, one of the most

modern and productive in the world. The workshop served four hundred fifty clients, of which two hundred were mildly retarded, fifty moderately retarded and the rest mentally ill patients. Although privately administered, it receives up to seventy percent of its budget from the National Social Welfare Ministry. In terms of modern management and industrial standards it would compare favorably with many private industries. The physical plant was new, modern, and functionally designed. The workshop itself was divided into a variety of units; administration, cafeteria, leisure or recreation section, work evaluation and testing, and a multiplicity of work areas or stations. Here also, heavy use of industrial equipment was the rule rather than the exception. Such complex work as bicycle and typewriter assembly were noted.

The second major facility visited in the Netherlands was the Huize de Benckhorst, an eighty acre institution for three hundred thirty-six moderately and severely mentally retarded boys. This new facility, located in Hertogenbasch, Holland, was operated by one of the largest Catholic Church foundations in Holland. This particular foundation operates nearly thirty other facilities for the retarded, mentally ill, and other handicapped, mainly in South Holland. The Huize Institution employed two hundred thirty staff members. This modern Dutch institution more closely typifies the traditional American "medical model" comprehensive institutional concept. Although modern, clean, and possessing therapeutic, vocational and educational programs, it did not exemplify any attempt to normalize or individualize its program for the retarded. The team saw wards with beds for ten or fifteen patients, common showers, dressing areas, etc.

In England visits were made to a children's home, a special school, a workshop, and two hostels. An excellent level of coordination exists which allows for a full interchange of information and program planning within the single administrative unit. In order to most effectively observe an exemplary comprehensive program, a visit was made to Oxford. The city of Oxford program is an independent unit closely related to the county of Oxford and operating under the basic regulations and major funding support of national agencies. Although not based on the normalization process found in Scandinavia there were many similar aspects (perhaps stemming from the social welfare base in Great Britain). No waiting list is in evidence; in fact the facilities all try to operate below capacity and thus provide short term crisis care when this is needed.

In the small twenty-bed children's home, rooms were either single or double. This home and the special school, with a population mainly of day students, share attractive grounds in a residential setting of small homes. They blend into the neighborhood with no institutional look or feeling. Perhaps the finest examples of concern for the individual were seen in the workshop. Several moderately to severely retarded girls were making cloth gloves and when asked what they were making they replied "cloth gloves that painters in the auto factory use and then throw away." The whole concept of being a vital cog in a work world came through very clearly. Near the workshop were two hostels, one for men and a larger co-educational unit. In the small hostel no staff were assigned and the men fully cared for themselves with the exception of an evening meal at the large hostel.

Wisconsin

Wisconsin, a midwestern state with approximately 4,246,000 citizens, is similar to Georgia in size of population, area and population distribution. Like Georgia, Wisconsin has one large city, Milwaukee, several smaller cities, and large sparsely populated rural areas. Wisconsin is known throughout the nation for the excellence of its services to the mentally retarded. The service system is organized under the Bureau of Mental Retardation of the Division of Mental Hygiene, which is a part of the Department of Health and Social Services. Residential services are provided at three large institutions, Northern, Southern and Central Wisconsin Colonies. Approximately eighty-five day care centers throughout the state provide training services and sheltered workshops for six thousand persons not served by the school system. Special education classes for educable and trainable children are provided in over one thousand classes. Extensive use is made of private residential facilities and nursing homes, which are regulated by state standards.

The project staff member visited Central Colony which serves primarily multi-handicapped children. Approximately eighty percent of the population is classified as profoundly retarded; many have orthopedic handicaps. The quality of the medical, social and recreational services received by the patients was judged to be outstanding. The enthusiasm and professional qualifications of Central Colony's staff seemed excellent. A staff ratio of 1:8 in direct care personnel is maintained. In addition to residential services, Central Colony provides comprehensive diagnosis and evaluation for out-patients from the entire state.

The Madison Opportunity Center was visited. This is a modern workshop offering vocational rehabilitation services to all disability groups, but primarily the mentally retarded. A variety of subcontracts were available, offering diversity in gaining job skills. The types of tasks these young adults performed should recommend them to future employees for competitive employment.

Saint Coletta's, a private residential facility for the retarded, was the last facility visited.

Outstanding features of the Wisconsin system are:

--Excellent services for severe and profound offered at Central Colony.

--Excellent network of day care and sheltered workshop services.

--Comprehensive diagnostic and evaluation services provided through approximately thirty-five regional mental health centers.

--Special education classes for TMR and EMR which meet a significant portion of need. Transportation expenses are absorbed by state.

--Extensive use of proprietary nursing homes. In 1968 the residential institutions placed six hundred seventy-four residents in one hundred

twenty-one nursing homes in the state. Over one thousand in all are served in such facilities. One hundred seventy mentally retarded persons were served in family care settings, and forty-three in halfway houses.

--A good Work Study Program for retarded adolescents offering adequate counseling and training.

Connecticut

Connecticut is a small state geographically, largely urban and densely populated, and covered by a network of excellent highways which makes travel within the state very rapid. This made it possible to visit a number of facilities and see many different kinds of programs.

In 1959, two major pieces of legislation were passed, one providing for mandatory public education for the trainable and educable and the second creating the Office of Mental Retardation within the Connecticut State Department of Health. At that time, the waiting lists at the two residential institutions, Mansfield and Southbury, were so large that a third institution was needed. The staffs of the institutions and leaders of the parents group supported the idea of alternative regional services which would provide small residential units plus day training and other services in a number of population regions. This idea was adopted; at present, services in Connecticut are organized around twelve regional centers.

On the first day the staff member visited Seaside Regional Center located on Long Island Sound. Children were engaged in various activities on the spacious grounds, riding bicycles, playing on the beach or swimming, or in the outdoor wading pool. Many volunteers and Foster Grandparents were observed in activities with the residents. Children from the region were bussed in for day camp activities. The Center has a new activities building used for both residents and non-residents, and a new cottage providing an independent living setting for young adults. Seaside maintains a group home, the Jay Sea House, in New London, for young men and women working in the community.

The Dempsey Regional Center at Putnam provided an example of a center serving a region comprising small towns and rural areas. The Center buildings were new, bright and attractive with two residential cottages serving forty-four, an Administration building housing all the regional staff, and an Activities building serving both residents and non-residents in preschool and sheltered workshops. The Sheltered Workshop in Putnam serves Center residents as well as handicapped persons of several other etiologies. The workshop employees were assembling and packaging components for electrical equipment and surgical supplies.

One day was spent at Mansfield Training School. The oldest facility in the state, Mansfield was an outstanding example of modern programming in spite of outmoded, less than ideal, physical plant. Innovative programs included a new unit for blind retarded, a cottage housing severely retarded

older women which had been especially decorated to provide a stimulating environment, an experimental residence for older severely retarded men and women, and a large workshop including the candle factory for "Flame of Hope" candles.

Mansfield's most outstanding program was the Community Group Home Program which at that time operated two homes in Manchester and five in the Hartford area. The group home in Manchester was comfortable and attractive with pleasant bedrooms for one or two persons, attractive sitting rooms and recreation areas. House parents operated the home like a small boarding house and gave supervision, attention and encouragement to the fifteen residents who were employed in the town.

In Hartford, a new fifteen unit apartment building leased by Mansfield served as a residence for adults nearly ready for complete independence. The furnished, one-bedroom apartments were attractive and comfortable. A resident staff person assisted with budgeting, banking, food shopping and food preparation where necessary. The cost of maintaining residents in the group homes was said to be approximately half that of serving them in the institution.

The New Haven Regional Center maintained offices in the inner-city areas and served a number of Spanish speaking clients. Services were offered to one hundred children and adolescents in need of residential care. Seventy percent of the residential admissions were for short term care. A large sheltered workshop served young people from the community and from the residential cottages. The Center was active in regional services, working with other agencies and parent groups in the establishment of outlying preschool and recreation programs.

Outstanding features of the Connecticut system are:

--Administrative design - The establishment of the Office of Mental Retardation as a separate entity under the State Department of Health, which has its own Deputy Commissioner and receives an adequately funded budget.

--Regional organization - The organization of the service delivery by regions makes such services widely available to those who need them, and allows needs to be met and problems solved at the lowest levels of organization.

--Personnel - The recruitment and retention of able personnel who seem well motivated, innovative and energetic. This seemed true at all levels of staff, and perhaps reflects an adequate salary level, particularly for the direct care personnel. The starting salary for the mental retardation aide series in 1970 was $5,507.00 per year. Many of the staff members were younger people, and those not so young in years seemed youthful and flexible in their approaches.

--Concept of retarded as developing persons - Connecticut's programs and residential facilities are based on the concept of the retarded as

developing persons and not as sick persons. Therefore training and habilitation, rather than medical care, are the major goals of the program. Administrators of the programs are largely drawn from disciplines other than medicine.

Summary of Site Visits

In assessing these programs, the visiting teams were concerned with four areas:

Quality - as exemplified in Holland's excellent workshops.
Quantity - as seen in Connecticut's accessible and diverse services, and Wisconsin's community programs.
Effectiveness and efficiency - as exemplified in the "normalizing" Danish programs which develop the retarded to their maximum potential.
Change of program emphasis and flexibility - as seen in the Scandinavian programs.

However, all the answers to Georgia's needs are not be be found in programs in Europe, Wisconsin or Connecticut. The ideas expressed in these programs must be adapted to fit our community needs. The most important result of these visits was the realization of the fact that the "normalization" principle can and does work. There is no reason to think that these concepts cannot be expressed in Georgia's own programs. The visiting teams saw highly stable staff organizations with tremendous pride and morale. They saw retarded adults in Europe doing work tasks thought in America to be too difficult for them. They saw many levels of semi-independent and independent living not often seen in Georgia. The primary task now is to translate these concepts and observations into improved community and residential services in Georgia.

The Model Comprehensive Service System
and
Existing Community Services in Georgia

THE MODEL COMPREHENSIVE SERVICE SYSTEM

After visiting exemplary facilities and systems in this country and abroad in the summer of 1970, the Residential Study Project staff together with members of the Professional Advisory Committee identified and listed what they considered the most important elements of a comprehensive service system for the mentally retarded of Georgia. This system was developed during a series of conferences. The staff considered the views of mental retardation specialists as expressed in recent literature in the field, as well as their own observations of programs here and in Europe. They sought to combine the best concepts and philosophy of service in the design of the model. In addition, they considered the history of Georgia's services, the priorities of the present system as expressed in existing services, and the additions and changes necessary to fill unmet needs.

How had Georgia historically met the needs of retarded citizens? Up until the end of World War II, nearly all services for retarded persons were provided in Gracewood State School and Hospital and Central State Hospital, large multi-purpose institutions. Scattered programs in the public schools, such as "opportunity classes", ungraded classes, etc. served a tiny fraction of the retarded persons living at home. In this, Georgia followed a nationwide pattern. The founding and organizing of a national parent group, the National Association for Retarded Children (NARC), in the 1950's heralded a new era in the development of services. Strong pressure on educational systems, health departments, and childrens' services by local units of this group brought new programs into existence in communities all over the country. The appointment of the President's Panel on Mental Retardation during the Kennedy administration and its subsequent report initiated planning in all the states, and prompted federal legislative programs and funding. In twenty years there has been a great and gratifying increase in services, particularly at the community level.

For most retarded citizens, community services are more appropriate than institutional care. Children can remain a part of their families and receive the parental love and interest that is necessary for good personality development and social adjustment. If a full array of services is available, retarded persons may remain in the community for all or most of their lives. Community based programs reducing the length of institutional placement are also much less expensive to the taxpayers. In Georgia, for example, a severely retarded child living at home in 1970 could be served in a day training center for $4.50 per day, whereas institutional care cost from $9.76 to $33.20 per day, depending on the institution. In view of this, it is evident that a wide range of alternative services at the community level should be provided.

Unfortunately, priority for such services is not reflected in present state budgets. In June 1970, 4,420 residents were receiving services in Georgia institutions at a cost of approximately $20,000,000. These residents represent about three percent of the total number of the mentally retarded in Georgia. For the severely and profoundly retarded remaining in the community (the responsibility of the Health Department) only $200,000

was budgeted for Fiscal Year 1970. Subsequent years have seen budget increases up to $700,000; still only a small part of the need is met. Existing residential facilities must of course receive the necessary funds to allow for continued improvement in the quality of care and training. But in all future planning, increasing portions of the budget should be allotted to comprehensive community programs. This is both humane and practical.

Earlier in the report, the concept of a "continuum of care" for the mentally retarded was introduced. This concept was defined in the report of the President's Panel on Mental Retardation's "National Action to Combat Mental Retardation" (1962). Essentially, it describes "the selection and use in proper sequence and relationship of the medical, educational and social services required to minimize the mentally retarded's disability at every point in his life span." The retarded person requires all the services afforded the normal person, though he may need them to a greater or different degree, and in different life periods. In addition he may need specialized procedures and programs especially tailored for him. These should be provided by generic agencies as a part of their regular services, if possible, or in specialized facilities, if necessary. The family may require augmented or differentiated services in dealing with this handicapped child.

If the family is to be assisted in maintaining a retarded child at home, an entire range of services should be provided both the child and the family. The aspects of the retarded person's life which are to be supported by special services and those which are not, must be determined. The model developed by the project study group is shown in table form in Appendix E. In designating the level of function for which the various special services are designed, the classification system adopted by the American Association on Mental Deficiency (AAMD) will be used. These levels, together with developmental characteristics are shown in Appendix F. IQ scores, though no longer accepted as a complete measure of an individual's functioning, provide a convenient way of grouping for planning.

The various elements of the comprehensive service system are discussed in detail in the following sections. In so far as possible, they are introduced in the order in which they might be required by the retardate and his family.

Diagnosis and Evaluation Services

To be considered for special services, the retarded person must first be identified as a person with special or extraordinary needs. The child who functions at the profound, severe or moderate level will probably be identified in preschool years. The child functioning at the mild level may attend school for several years before identification. Whenever a child is suspected of mental retardation, he should have access to a comprehensive diagnostic and evaluation service. This should offer coordinated medical, psychological and social evaluations, combined with developmental, nutritional, educational and vocational evaluations if appropriate. These services should be provided by personnel qualified to determine the needs of the retarded person and his family, to offer initial counseling, and to make appropriate referrals.

Early Detection

Early diagnosis and intervention are especially desirable in the child who functions at a low level. Proper management and training at an early age are vital to the growth and potential of such children. The effects of poor family attitudes and management techniques are long lasting and difficult to overcome. Good counseling is essential at this stage in making plans for the child's future. Diagnosis of young children should include, if indicated, laboratory tests, chromosome studies, evaluation of sensory and psychological functions. Programs should be planned in areas of deficit. Regimes of medication, diet, and corrective procedures should be planned and implementation arranged for.

Fixed Point of Referral

There should be available in each community a "fixed point of referral" and information, which will offer guidance to the parents or guardians over the entire life span of a retarded person. In Georgia, this point of referral should be the local health department, or health district office. Although school systems may identify mentally retarded children, they usually cannot provide lifetime counseling and referral programs.

Follow-Up and Re-Evaluation

Once identified and placed in the proper program, the retarded person's activities should be followed-up at regular intervals, and re-evaluations scheduled on a regular basis. As he grows older, additional educational and vocational evaluations may be needed. Whether placed in community programs or institutions, at regular intervals his progress should be checked and the suitability of the program considered. If necessary, the programs should be changed or new services offered.

Family Services

No matter how many services may be given directly to the retarded person, his family needs much help from the community if it is to remain intact and healthy. The shattering impact of learning that a child is retarded is one of life's most painful experiences. Retardation is a lifelong problem which will never be completely resolved, and requires continuing adjustment and accommodation. The stresses of such a problem not uncommonly result in the deterioration and breakup of the family. If a family is to function well, and preserve the rights of all family members, the community must provide supporting services.

Counseling and Referral

At the time of initial diagnosis, continuing counseling should be available. Often parents do not grasp all the implications of the diagnosis when first informed and may need to return for further sessions. They need opportunities to learn about retardation, and to talk with other parents with the same problem. They need assistance in planning for the child's future, from someone who knows the resources of the community. They need referrals to programs, and sometimes help in getting placement for their child. At each time of the child's life when changes are necessary, they will need to return for further counseling and assistance.

Parent Relief

In addition, the parents will need relief from the sometimes arduous task of managing a retarded child. They will need baby-sitters, and places to leave their child for vacation trips. Often these are not available from relatives or the normal sources in the community. At periods of stress, such as illness or death in the family, they may need homemaker services (home helping services, visiting homemakers) in order to keep the household operating. Or the mother may simply need some time alone with other family members, or a chance to take a much needed outing. Some families can never do anything as a unit. Some or all of these services will be necessary as long as the retarded person remains in the family home.

Mental and Physical Health Services

Basic Health Care

All retarded children should have access to basic health care, provided either by private physicians, well-baby, or child health clinics at local hospitals or health departments. Routine check-ups and immunizations should be provided. Through the lifetime of the retarded person, he should have access to good basic health care. When family financial resources are limited, services may possibly be provided through health insurance, Medicaid, or if eligible, Medicare.

Corrective Procedures

In addition to the usual childhood diseases and health hazards, the retarded child frequently has speech, visual, hearing or dental defects. Orthopedic and neurological problems are often found, particularly among the more severely handicapped. Corrective procedures should be prescribed and carried out to bring the retarded child to the highest functioning level possible. The infant with special medical problems should be followed-up. Procedures often considered to be cosmetic in value such as corrections of strabismus (cross-eyes), orthodontics, plastic surgery, are sometimes not provided the retarded person on the grounds that since he will not lead a normal life, it is not important for him. On the contrary, the retarded person needs every help he can get to make him function better, look better and feel better about himself.

Genetic Studies

In cases where chromosome aberrations or inborn errors of metabolism may be suspected, special laboratory and genetic studies should be done. The retarded person's parents and family members should be provided genetic counseling services if indicated.

Psychological or Psychiatric Treatment

A retarded person may also become emotionally maladjusted, and require psychological and psychiatric treatment. Resources available to others should be open to him, if and when he needs them.

Counseling

Many mildly retarded adults marry and have families. Premarital counseling should be provided, with information about contraceptive procedures and family planning. If marital problems arise, the retarded citizen should have access to counseling.

Education and Training Services

The retarded person needs specialized education and training opportunities. The term "day training" refers to programs operated by the health department or private agencies serving primarily the moderately and severely retarded preschool children, the severely retarded school age, and the moderately and severely retarded adult. The term "special education" describes programs for the mildly and moderately retarded taught in public schools by special education teachers.

Preschool Services

Children identified as retarded during preschool years should have access to training programs designed to meet their needs. Interest in preschool training of all children is increasing as our knowledge of the

impact of early childhood education widens. Preliminary results of the Milwaukee study have been very encouraging and point to intensive early training as a method of preventing mild or cultural-familial retardation. Preschool children from culturally disadvantaged homes or high-risk families should be offered such programs of stimulation and enrichment which are available in child development centers and kindergartens.

The moderately retarded preschooler should attend day training classes which emphasize self-care skills and language development, preparing him either for trainable mental retardation programs in the public schools or further day training.

Severely and profoundly retarded preschoolers are probably not ready for group programs. Efforts should be made to assist parents in teaching their children simple skills at home. With the help of a public health nurse or a home visitor service parents can develop skills in training and managing such children. The non-ambulatory child with severe orthopedic or neurological problems should receive the services of the public health nurse and a consulting physical therapist who can advise parents on techniques which might prevent the development of contractures and deformities.

Services for School Age Mentally Retarded

School age children who meet special education criteria should be enrolled in state supported classes for the educable and trainable mentally retarded. The education programs should provide them with necessary academic skills, as well as work training, to prepare them for an independent life if possible. Severely retarded and profoundly retarded who are able to function in a group should be served in day training centers. By participating in a developmentally oriented program, retarded children learn to function better as adults. For those children unable to attend group programs, or conform to such settings, home training and family counseling should be continued.

Services for Adult Mentally Retarded

Mildly retarded adults should receive continuing educational services through public school sponsored adult education programs, both in academic and technical schools. It has been observed that mildly retarded young adults often are more highly motivated to learn than they were at the secondary level. This motivation should be capitalized on by providing appropriate programs in remedical subjects.

Continuing training both in academic and work skills should be programmed in sheltered workshops, work activity centers, and activity centers for the moderately, severely and profoundly retarded adult.

Work Training

Most mildly retarded persons possess considerable work potential and can become self-supporting if provided adequate work training services. Naturally, it is of great value to the retarded citizen and the community when he becomes a wage earner. It prevents him from becoming dependent on society, and adds valuable members to the work force. In the moderately and severely retarded, the work potential is more limited. However, in some European countries, moderately retarded individuals are producing well in sheltered work settings. Every retarded citizen should have access to a program of work training.

During secondary school years, the mildly retarded should receive vocational evaluation, counseling and pre-vocational training through co-operative programs between the school system and the Division of Vocational Rehabilitation. After school, job placement services and follow-up should be provided. If additional training is necessary, a transitional workshop should be available.

A small percentage of the graduates of programs for the TMR (moderates) may be capable of community employment and should receive services directed toward this. Many more can be trained as extended employees in work activity programs, similar to sheltered workshops. Such workshop programs are seen as a long term placement for those mentally retarded individuals requiring lifetime supervision.

Work activities should be introduced into the school programs of the older moderate and severely retarded. All through the school age years, good work habits should be stressed. Those who function well in work activity programs may progress to sheltered workshops, where they will be workshop employees and be able to earn wages. Such programs will require a modest subsidy. A limited number of sheltered workshop employees may be able to progress to competitive employment in the community. Sheltered workshop services should extend indefinitely for those who participate.

Economic-Legal Supportive Services

Protective Services

It is assumed that the family will be responsible for the supervision and protection of the person and property of the retarded person at least until he reaches adulthood. Unfortunately, some families neglect or mistreat their children, and it is necessary to provide for protective services. Placement outside the home may be necessary and legal custody may be invested in another person or agency.

Guardianship

The death of the parents or desertion by them may require guardianship of the person and property of the underage or legally incompetent retardate. It should not be necessary to institutionalize a retardate simply because of the death of parents. Resources should be available to protect his human and civil rights.

Citizen Advocacy

There are retarded persons, especially in institutions, who have no friends or interested relatives, and who never receive visits, mail, gifts or calls. One of the ways developed to meet this need in other states is the citizen advocacy program. This provides for a one-to-one relationship between an interested citizen and the retarded person who needs help. Different levels of involvement may be required. It may be an informal relationship, with the citizen as a friend or counselor. Such assistance as obtaining social security or welfare payments or filling out forms might be all that is necessary. It may be more formal and include guardianship, foster parenthood or adoption, or protection of the civil rights of the individual.

Income Maintenance

The older retarded person who is unable to be independent or self supporting will require income maintenance. He may be eligible for social security benefits from the accounts of retired or deceased parents. After age eighteen, if he has no property or income in his own right, he is eligible to a monthly allotment from Aid to the Permanently and Totally Disabled.

Recreation Services

The retarded person, like normal people, needs leisure time activities. Often isolated within his own neighborhood, he misses the spontaneous and informal recreation available to others. In addition, he may not have the ability to plan for his own activities, and so needs more help from community agencies. The mildly retarded person is often able to participate in regular recreation programs if encouraged to do so. The same agencies providing recreation for normal persons - such as city recreation departments, YMCA and YWCA, senior citizen groups and church groups - should include the retarded in their planning. Lower functioning persons may need programs modified to suit their specific physical and learning abilities.

The retarded child needs active, stimulating play activities such as might be provided in organized playground groups and modified athletic programs. Day camps should be provided during summer months when school related activities are interrupted. Boy Scout and Girl Scout programs offer opportunities for socialization, learning and being a part of activities of normal children. When the child is mature enough to live away from home for short periods, he may attend a residential camp. Such experiences are often invaluable in reducing excessive dependency on family members, besides affording the other members of the family time to themselves. The retarded adolescent needs wholesome social activities with others of his own age group.

Needs for organized leisure time activities do not decrease as the retarded person grows older. Many people working in the field have observed the apathetic often obese older retardate who spends much of his life in sedentary activities. He could benefit from structured physical activities, such as swimming and bowling, planned exercises, etc.

Like normal people, retarded persons need breaks in their yearly routine. Holiday celebrations and short trips during vacations should be planned for them.

Religious Training

Retarded children should be able to participate in religious worship with their own families. A number of churches in Georgia have organized church school classes specifically for retarded children and adults, which accept members of any faith. In cases where retarded persons wish to affiliate with the church, and are able to understand their responsibilities as church members, they should be able to do so. Some denominations have modified their membership training in ways which enable retarded persons to become members. The ability to attend church services and other fellowship functions gives them opportunities for normalizing experiences.

The inclusion of mentally retarded persons in church activities gives wider visibility to the problems of mental retardation in what should be an accepting and supporting group. Families of retarded persons may receive comfort and support from their fellow church members, and often turn to their minister, priest or rabbi for counseling when they have problems.

Transportation

It will be useless to develop all facets of a comprehensive community service system unless programs are accessible to the retardates they are designed to serve. Many families cannot afford automobiles or daily bus fares. Lower level retarded persons cannot travel unsupervised on public transportation.

In planning any ongoing program for the retardate living in the community, transportation should be an important consideration. It is common for services to be developed only to find that a large number of eligible participants have no way of getting there. If the program does not furnish its own buses, it should have firm commitments from other agencies such as school systems or volunteer groups to provide transportation.

Programs which will need transportation are: Mental and Physical Health Services, Education and Training Services, Activity and Work Activity Programs, and Recreation Services.

Residential Services

Many professionals in the field of mental retardation believe that it is best for the retarded child to live in the family home as long as this is possible. For the great majority of retarded persons, lifetime institutional care is not appropriate. Even the best residential institution is a poor substitute for an adequate home. However, it sometimes becomes necessary for a variety of reasons to place the retarded child outside the home. These reasons may include the death of parents, breakup of the family for other reasons, destructive effect of the retarded child's behavior on other family members, inability of the family to meet the needs of the child, even cruel or neglectful treatment. If a child must be removed from his home, there should be a number of different sorts of residential placements available to him. The large multi-purpose institution far away from his family should be the last alternative.

In Georgia, at present, the retardate unable to live at home has few choices. There are three facilities designed especially for the mentally retarded, Gracewood State School and Hospital, the Georgia Retardation Center at Atlanta, and the Athens Unit. Other residential placements for the mentally retarded are afforded as a part of mental health services at Central State Hospital, Georgia Regional Hospital in Atlanta, and Southwestern State Hospital. The regional hospitals under construction and planned for the future are designed primarily for the mentally ill; some will include units for the mentally retarded. All of these facilities are planned on the hospital model, organized under physicians and nursing staffs. Many of the mentally retarded residing in these facilities are far from their homes, although the Georgia Retardation Center at Athens and the Georgia Regional Hospital in Atlanta admit on a more or less regional basis. Only Georgia Retardation Center at Athens regularly sends its residents home each weekend.

In order to provide as "normalizing" an atmosphere as possible, residential facilities should not only be close to the retardate's home, but they should be small. Living units probably should not serve more than ten to twelve persons. While there may be a number of small living units in a larger residential complex, the complex itself should be fairly small or it is likely to become "dehumanizing." The larger the institution the more it tends to be self-contained and separated from the community. In order to be effective, the small units of care should have specialized programs suited to their population. These programs should be administered by professionals trained in the discipline most appropriate to the program.

A complete array of residential placements should include the following services:

In the Community

--Residential Service Type 1 - Foster Care. Foster home care, especially for young children and infants is the most desirable placement outside the child's natural home. A concerted effort should be made in Georgia to locate foster home parents willing to accept retarded children.

--Residential Service Type 2 - Childrens Boarding Home. There will be some retarded persons of all ages not requiring medical or intensive training care (Residential Service Type 5 and 6) who will need placement outside the home for a number of reasons. The home environment may not be suitable, the parents may be absent or dead. Some children while not presenting particular problems in care but may still be rejected completely by the family. Boarding homes serving eight to ten children should be established wherever possible by age groups. Homes for young children should stress child development programs, training in self-care skills, etc. Older children, up to age twelve, need a good home environment and continuing training in daily living skills. They should attend training programs in the special education classes or day training centers located in the community. Adolescents need continued homelike atmosphere and supervision; they should attend community training classes or participate in vocational training.

--Residential Service Type 3 - Hostel. This living unit is seen as transitional, preparing retarded persons over the age of eighteen for independent community living. The residents should attend vocational training centers, or on-the-job training. The hostel program should teach money management, good consumer practices, sex education, etc. Residents should participate in household chores. The average length of stay would be about one year.

--Residential Service Type 4 - Adult Boarding Home. This service should provide a long-term sheltered living setting for the older retarded person who can work in the community or a sheltered workshop, but can not function well enough to live completely independent of supervision. The residents should pay room and board from their earnings if able. The older retardate might live in such a unit as long as he was healthy and capable of self-care. Such homes should be organized to be relatively homogeneous in their grouping.

In Existing Institutions

--Residential Service Type 5 - Medical Care. Residential care will be required for retarded persons of all ages who have serious medical problems requiring skilled nursing care not available in the home. Patients with hydrocephaly, spina bifida, difficult feeding problems, extensive paralysis are examples. Some beds for infirm geriatric patients will also be needed.

--Residential Service Type 6 - Intensive Training. Residential care will be required for retarded persons of all ages whose behavior problems are so severe and disrupting to the family that they can not be managed in the home, or in a community group home. A number of the severely and profoundly retarded may need an intensified behavior modification program which can not easily be carried out by the family. Retardates whose behavior is antisocial will need a highly structured, high security program. With effective training programs, some of these persons could be expected to return to their homes, or transfer into other types of programs.

In Space Reserved in Residential Service Types 1 - 6

--Residential Service Type 7 - Respite Care. This service should give temporary placement of up to one month to children of families in need of relief from the care of the child. Such needs may arise from family crises such as death, birth, illness of a family member, divorce or separation. The need may come from lesser events such as moving, a vacation or holiday trip.

--Residential Service Type 8 - Short-Term Care. This service should give temporary placement for longer periods, from six months to a year. Children might be admitted for special training programs in some specific areas, or to enable special medical procedures to be done. Respite care needed because of longer term family problems might be extended into short term care.

It should be stressed that all placements must be subject to scheduled review to determine that they meet the child's present needs. The system should maintain utmost flexibility. As the child's needs change due to his growth and development, the program should change.

EXISTING COMMUNITY SERVICES IN GEORGIA

After considering all the elements of the comprehensive service system, several questions should be asked. Which of these services are being provided in Georgia? Where are they located, and what percentage of the need do they meet?

Services for Georgia's retarded citizens have been developing rapidly in the last few years and a great deal of progress has been made. However, there are still many unmet needs. In urban areas where there have been strong parent groups, community agencies have responded with programs. In rural areas and small towns, services are at best spotty in distribution, and in many instances non-existent. There were some Georgia counties in 1970 which had no services of any kind for the mentally retarded located within their borders.

In the following discussion, the order of services will follow that of the Comprehensive Service System. Most of the information reported was compiled in 1970.

Diagnosis and Evaluation

There are three Diagnostic and Evaluation Clinics operating in DeKalb, Muscogee and Chatham Counties through funds provided by the U. S. Department of Health, Education and Welfare. These clinics give very comprehensive evaluations by interdisciplinary teams to children suspected of mental retardation. They serve a combined total of seventeen counties.

Outpatient evaluations are also available through five Georgia institutions: Gracewood, Central State, Southwestern, Georgia Retardation Center, and the Athens Unit, GRC. The last two facilities have only recently begun to offer this service. For a number of years, institutions provided evaluations only for applicants for the institution waiting list. Now, however, it is possible to apply on an outpatient basis for evaluation only. It weems likely that this service will be increasingly used as physicians and parents become aware of its availability.

Some special elements of diagnosis and evaluation are provided by generic agencies in Georgia. Psycho-educational evaluations may be obtained through the School Psychology Services of the Georgia Department of Education. Diagnostic facilities for handicapped children, including those with mental retardation, are provided by Grady Hospital in Atlanta through the pediatric clinics and Birth Defects Special Treatment Center. Similar services are available at Talmadge Memorial Hospital in Augusta. Egleston Hospital and Emory Clinic in Atlanta provide some diagnostic services, mostly to patients of private physicians. The Georgia Center for the Multi-Handicapped accepts patients for short term residential evaluation; among the handicapping conditions served is mental retardation. State universities and colleges furnish evaluation services in connection with their teacher

education programs. These are Georgia State University, University of Georgia, West Georgia College, Atlanta University, Georgia Southern College and Valdosta College. Vocational appraisals for mildly retarded teenagers and adults are a part of the services offered by various units of the Office of Vocational Rehabilitation Services.

In many counties, families must go considerable distances to get evaluations for their children. There is a great need in Georgia for easily accessible, inexpensive, comprehensive diagnostic services. Attached to or closely connected with these programs should be the "fixed point of referral" and source of lifetime counseling for the families of the retarded.

Family Services

Family counseling and parent education services specifically related to mental retardation are presently available only in association with other programs such as diagnostic and evaluation clinics, public school or day training centers, child guidance programs, etc. Public health nurses are often a source of referral and parent education to families. Other generic agencies, such as Family and Children Services, may have parents of the retarded among their clients.

Within the last few years, respite or short term care has become available at some of our state institutions. The 1971 legislation prorating the annual cost of residential care to allow for short stays should enable more parents to take advantage of these placements. There are volunteer efforts to provide baby-sitting services in some communities but these are not wide spread. There are no known homemaker services particularly designed for families of retarded children.

Mental and Physical Health Services

Basic health care is provided retarded persons by private physicians or Maternal and Child Health Services in the local health departments. Two special Maternal and Infant Care programs located at Talmadge Memorial Hospital in Augusta and Grady Memorial Hospital in Atlanta, serving thirteen counties in all, follow high-risk mothers and infants in an effort to prevent and detect mental retardation. Corrective medical procedures are furnished either by private physicians, the Crippled Children's Service, or the Birth Defects Centers operated by Grady and Talmadge Memorial Hospitals. Mentally retarded children are eligible for certain Easter Seal Society services which include physical therapy, occupational therapy, speech therapy, vocational evaluation, camping and recreation programs.

Education and Training

Since the passage of HB 453 in 1968, every school system in Georgia is mandated to provide public school services to the mentally retarded by 1976. The Program for Exceptional Children, State Department of Education,

works with local systems to develop and coordinate these programs. Special education teachers are allotted to the various school systems by the State Department of Education, and their salaries provided. In 1971, there were 1,248 EMR classes in 167 school systems, providing places for 19,746 children. This is estimated to meet approximately 58 percent of the need. There were 96 TMR classes, serving 960 children, meeting approximately 26 percent of the need.

Day training centers serve many retarded children and adults not eligible for public school or vocational rehabilitation services. In June 1971, seven such programs were operated by local county health departments. In addition, there were fifty-one private programs conducted by associations for retarded children, civic, and church groups. Thirty-three of the private groups received funds from the State Health Department through the Purchase of Service program. These facilities serve a total of 1,566 retarded persons, estimated by the Health Department to represent approximately thirteen percent of those needing services. These programs tend to be concentrated in urban areas; 517 of those served live in the Metropolitan Atlanta area. By health districts, there is a variation in percentage of need met from five percent in rural areas to nineteen percent in more densely populated districts.

Work Training

The Office of Vocational Rehabilitation provides a number of services to retarded persons functioning in the mildly retarded range. These include: psychological, medical and vocational evaluation, vocational guidance and job placement. At present there are ten vocational evaluation centers located in Georgia.

The department provides also a cooperative work training program with secondary schools which offer special education services. Two pre-vocational centers in Atlanta and Macon provide evaluations and work conditioning. Pupils divide their time between the school and the pre-vocational centers.

Work training and evaluation programs are provided in Gracewood for residents and outpatients, and at Central State, Southwestern, and Georgia Retardation Center at Athens for residents.

Workshop services for those who need additional training before entering competitive employment are available in Atlanta, Savannah, Albany, Columbus, Rome and Augusta.

Work activity centers for moderately and severely retarded adults are being operated or being developed in connection with a number of existing day training centers.

Economic-Legal

The Department of Family and Children Services offers a number of services which are available to the mentally retarded. For those mentally retarded persons over eighteen years of age unable to work who have no personal income, financial assistance through Aid to the Permanently and Totally Disabled may be arranged. If necessary, foster home placement is provided for children with no homes or unsuitable homes. Casework services such as counseling and referral are provided families of the retarded who are on the Department of Family and Children Services caseloads.

In addition, the Department has licensing responsibility for any private day care or residential facilities offering services to the mentally retarded.

Recreation

Recreation services to Georgia's retarded are provided by many different agencies and groups. Day training and educational centers supply some recreational activities as a part of their programs. Volunteers, civic groups, student groups, Youth ARC's, YMCA's, and church facilities plan recreational experiences for retarded children in many localities in the state. Local city and county recreation departments have developed some programs for the mentally retarded, but not in all areas, and not usually in a highly organized way. Examples of such recreational activities are day camping, swimming, and playground programs.

The Georgia Recreation Commission has sponsored several workshops for training recreation personnel in working with the mentally retarded. The Commission co-sponsored the Georgia Special Olympics in 1970 and 1971. A special residential camp for handicapped persons including the mentally retarded has been developed at Fort Yargo State Park.

Religious Training

Many churches in Georgia sponsor church school classes and special classes for religious instruction for the mentally retarded. The development of such programs seems to depend primarily on the special needs, and knowledge, of the particular church membership. In addition, a number of day training programs use church-owned facilities. Congregations furnish many of the volunteers who supplement staff services at these centers. A number of churches have sponsored recreation activities for retarded children and adults.

The Southeastern Methodist Agency for the Retarded has been involved in program development and provision of some direct services to the mentally retarded.

Transportation

Transportation services to mental retardation programs have traditionally been organized by the particular facilities concerned. These services are usually expensive and increase program costs a great deal. The availability of transportation seems to depend largely on the type of program funding. For example, centers funded by staffing grants often do not provide transportation. Programs under Title IV-A of the Social Security Act may include transportation in their budgets. Where transportation is not furnished, the burden falls upon the parents; consequently children from low income families are often excluded.

Bussing for students in public school special education programs is available in some systems, but not in all. Additional costs resulting from bussing special students must be absorbed by the local system at the present time. Independent school systems usually have no way of funding transportation. Under the provisions of HB 453, the State Department of Education is empowered to provide transportation. To date, this provision has not been funded.

Residential Services

The majority of those receiving residential services in Georgia are enrolled in the state's institutions. The status of these services will be reported in detail in the next section.

While there have been some funds appropriated for foster home services, placements have been few. The present program places only residents from institutions into foster homes.

There is one small private facility in the Atlanta area giving nursing care to approximately fifty non-ambulatory children. A small residential vocational training school has begun operation in North Georgia, but at the present time has less than ten students.

Status of Existing Residential Services in Georgia

STATUS OF EXISTING RESIDENTIAL SERVICES IN GEORGIA

In order to observe services at firsthand in Georgia's institutions, AARC staff members visited all of the currently operating residential facilities during the months of November and early December 1970. It should be emphasized that these visits were brief, and represent observations made only at one point in time. Necessarily, the team members relied largely on information given them by institution staff members; this was coupled with their own impressions. There have been extensive changes in service at some of the facilities since the team visits, particularly at Central State Hospital, which are not reflected in the report.

The visits were arranged with the superintendents; copies of the questionnaire, and a suggested schedule of activities were sent them. Five AARC staff members were assigned to a team making the visits. Each visitor was given special areas for study which were constant throughout the visits. In this way, it was hoped to develop more background in the various programs studied and more basis for comparison. The visit schedule included an interview with the superintendent, a general tour and overview of the facility, interviews with the various division and department heads, and visits to specific programs.

In studying the components of residential services, the team members gave special emphasis to factors judged by them to affect the overall quality of the resident's life style. Team philosophy might be expressed as: The ward or cottage is the resident's home. For some retarded persons, ward life represents the sum total of all their experiences. This home should be pleasant, comfortable and clean; it should provide opportunities both for interaction with other people and for needed privacy. Accordingly, more emphasis was placed on the typical resident's daily surroundings, levels of daily activities, and opportunities for interpersonal relations than on special projects and programs serving only a small percentage of the population.

The base of all the statistical data, where possible, is the Fiscal Year 1970. This data, requested from the institutions, was supplied in varying amounts. Due to the differences in record keeping systems and the lack of consistency in statistical coding, it was not possible to obtain compatible information from all the institutions. For example, Central State Hospital which has its own computer center furnished nearly all the data requested on Unit IX, the mental retardation program. Due to the fact, however, that over half the mentally retarded residents at Central State Hospital were scattered throughout the geographic units, it was not feasible to collect detailed information concerning their programs, although we were furnished general population data for these residents. The Georgia Retardation Center, which at that time was just installing its data-processing equipment, furnished very little statistical information. The Georgia Regional Hospital at Atlanta, having a very small mentally retarded population, prepared the statistics by hand. Gracewood State School and Hospital furnished us with much of the information requested, while Southwestern State Hospital was able to give detailed information on the Rosehaven Unit, but less on the mentally retarded patients assigned to the other units or to the Bainbridge Hospital. In order to supply some additional data, we

requested help from the BioStatistics Section of the State Department of Public Health. Working with us were the CCAA's Mr. Jack Schmitt and Mr. Charles Rogers who prepared the data received and assisted us in its interpretation.

In organizing the reports of the programs at the several institutions, the Georgia Regional Hospital at Atlanta, Athens Unit, Georgia Retardation Center, and Southwestern State Hospital were grouped together in the first section. These facilities are essentially special-purpose institutions, serving highly selected populations and providing specialized programs. Georgia Retardation Center, Gracewood State School and Hospital and Central State Hospital which are multi-purpose facilities serving all ages and levels of retardation will be reported on in the second section.

SPECIAL PURPOSE RESIDENTIAL FACILITIES

ATHENS UNIT, GEORGIA RETARDATION CENTER

ATLANTA REGIONAL HOSPITAL

SOUTHWESTERN STATE HOSPITAL

ATHENS UNIT
GEORGIA RETARDATION CENTER

The Athens Unit of the Georgia Retardation Center was completed in 1969, and began admitting students in September of that year. It was built at a cost of $1,690,000; furnishings and equipment cost an additional $300,000. It occupies a pleasant setting on the outskirts of Athens near the Oconee River, on property provided by the University of Georgia. The main building, a three-story brick construction, houses in its various wings the administrative offices, classrooms and resident living areas. Attractively landscaped grounds provide fenced play areas adjacent to the classrooms.

This facility is operated jointly by the Georgia Retardation Center and the University of Georgia to provide training for university students as well as services to mildly and moderately retarded persons. Approximately one-third of the budget is provided by the University; its share of funding is expected to increase in the future. The unit serves as a training facility for university students from fourteen departments including Special Education, Child Development, Vocational Rehabilitation, Speech and Hearing, Physical Education and Recreation, Social Work, Clinical Psychology, School Psychology, Counseling, Music Therapy, Reading, Sociology, and Pharmacy. Its service goals are to provide short term evaluation, treatment and training for eighty mildly and moderately retarded individuals from three to twenty-one years of age. Of these, forty are served in the residential program and forty as day students.

Admissions

Application to the Athens Unit, unlike all other applications for service in a Georgia institution, are not processed through the Hospital Admissions Office, but are submitted to, evaluated and approved by the Athens Unit itself. According to the original criteria, residents are to be selected from applicants who live more than one hour travel time distant, and day students from those who live within the one hour zone. The designated service area includes twenty-eight Northeast Georgia counties. Admission for residence is limited to a period of three to six months. Day students may be enrolled for a period of one academic year or less, at the discretion of the staff.

In addition to service-area and functioning-level criteria, individuals may not have orthopedic or medical disabilities demanding unusual attention, or severe behavior disturbances. Students are chosen to fit the training problems of the center, and an effort is made to keep a random population.

In the first year of operation, the Center has found it necessary to modify some of the original admission and grouping plans. Two residents have been admitted from outside the service area. Some students functioning as severely retarded have been served, and some with IQ's as high as 80. The preschool group, originally planned for ten, was reduced to six students.

Some difficulty was experienced in filling spaces in programs for the adolescent mildly retarded. Staff members believe that certain students may possibly need a longer time in residence than originally planned.

Soon after admission, an evaluation of each student is made by a multidisciplinary team consisting of the psychologist, nurse, teacher, speech and hearing therapist, physical educator, and others as deemed appropriate. The results of these evaluations are discussed at a staffing conference at which the resident's house-parent is present. A case summary is placed in the student's file, and is available to the program assistants and others working with the student. Each student's progress is reviewed once a month, or more often if necessary.

At the time of the site visit, there were forty-one students in residence, and thirty-one attending as day students. Six residents, and twenty-four day students had been released to community programs. Fifty-six applicants had been evaluated but not admitted for various reasons. The day student program represented the only outpatient service provided, although the staff had plans for diagnosis and evaluation services for outpatients in the future. If this service is initiated, additional staff positions must be budgeted.

Personnel

The Athens Unit is well staffed professionally. The University of Georgia shares staff with the Center and provides student trainees who work with the students under professional supervision. The Director is a member of the University staff.

Cottage Life staff members are screened by the Cottage Life Supervisor. An effort is made to recruit program assistants who can contribute to programming activities in specific areas such as crafts or hobbies, as well as providing personal care. The majority of the program assistants are under twenty-five years of age, and most are women. Although there is opportunity for advancement, the turnover rate has been high. This may be due to the fact that employees are drawn from the highly mobile population of a university town.

Initially, employees have orientation training which includes policy briefings. In-service education for program assistants is scheduled regularly, and covers such topics as first aid, arts and crafts, characteristics of retarded children, etc. Staff development programs for the professional staff members are planned and implemented departmentally.

Medical and Dental Services

Due to the selection factors used to admit students, only routine health care services are needed. Three registered nurses provide overall health care for students and also work with local public health nurses. A pediatrician serves the unit on a part-time basis, and is available on call.

If specialized services are needed, the medical staff of the Georgia Retardation Center at Atlanta may be consulted. Regular physical examinations and health check-ups are scheduled. Any prescription drugs necessary are purchased at a local pharmacy. If students need emergency hospitalization they can be admitted to Saint Mary's Hospital in Athens. During episodes of illness, parents may take their children home to care for them. Routine dental work is done at the Georgia Retardation Center at Atlanta; a local dentist may be used in emergencies. No special treatment programs such as physical and occupational therapy are provided, again due to student selection factors.

Education and Training Services

All residents and day students are served in the education and training program. Forty-five students were being served in five EMR classes, and twenty-six in the TMR and preschool programs at the time of the visit. Eight certified special education teachers, five furnished by the State Department of Education and three by the University of Georgia, staffed this program. Four teaching aides, drawn from the ranks of the program assistants serving in the dormitory units, were assigned to the classrooms. In addition, the University supplied personnel to provide thirty additional hours of classroom activity. EMR classes were provided for thirty hours per week, and TMR classes for twenty-five hours per week. The classrooms were attractive, well equipped and supplied with a variety of excellent teaching materials. Language development and speech correction programs were provided by speech trainees from the University. A part-time vocational rehabilitation counselor was assigned to the unit, but was not available for interview at the time of the site visit.

Psychological Services

A full spectrum of psychological services is provided at the Athens Unit. At the time of the site visit, the staff consisted of one full time and one part-time Ph.D. and two interns at the Masters level. Trainees from the University augmented staff services in many ways. Intelligence tests and behavior evaluations were administered to students on admission and at scheduled intervals thereafter. Psychologists were active in planning the educational programs for students, and also provided therapy and counseling services when needed, particularly for the EMR. A token economy had been set up with a group of younger children for behavior modification purposes. One family in need of counseling had been served.

Social Work Services

Two social workers, both members of ACSW, divided the caseload between them by classes. A number of graduate and undergraduate students from the University worked in the program. The Social Services Department received all referrals and did intake evaluations. Since initial admissions are completed, intake functions require less time. Detailed reports are kept in a medical records library and are available to house-parents and teachers.

Social workers participated in program planning for individual students, and kept in touch with public health nurses, agencies, etc. in the students' home community. They were responsible for follow-up of students returned to the community. Duties connected with maintaining family contacts were nominal since most children go home for weekends. Individual counseling was done with students when necessary.

Resident Care

Residents of the Athens Unit live in three fourteen-bed units in the dormitory wing. The physical surroundings compare favorably with a modern boarding school or college dormitory. Bedrooms for two are carpeted, attractively furnished and have private baths. There is ample space for clothing, personal possessions, with bulletin boards for souvenirs and photographs. Each unit has a comfortable activity room with lounge chairs, TVs, areas for games and hobby activities which reflects the individualities of the house-parents and students, much as a private home would. A small kitchen area is provided where snacks may be prepared and eaten.

Staffing patterns were similar to those at Georgia Retardation Center in Atlanta. Each unit had a house-parent who provided continuity of personnel for the students. An excellent staff-resident ratio was maintained, providing one program assistant for every 4.7 students in the elementary dormitory on morning and night shifts, and one-to-three on the afternoon shifts. In the adolescent dormitories, a one-to-seven ratio was maintained on morning and night shifts, and a one-to-five on afternoon shifts. Program assistants on the morning shifts also served as teaching aides in the classrooms. Additional assistants were scheduled for afternoon shifts in order to supervise leisure time activities. On weekends, skeleton shifts were maintained since most of the children went home. Staff-resident ratios exceeded those recommended by AAMD. Grouping appeared to be relatively homogeneous.

The students ate their meals in an attractive cafeteria on the first floor. Food service was contracted from the University of Georgia. On the day of the site visit, the food was well prepared, attractively served and in plentiful quantity. The kitchen, for serving only, was above average in appearance and cleanliness and seemed well-managed. TMR students ate lunch in the classrooms for training purposes. No food was prepared in the building.

Students appeared neatly dressed in their own clothing, and were generally well groomed. Most families furnished their own child's clothes, but some students received clothing through GRC at Atlanta. Laundry was sent out to commercial laundries, but parents did much of the students' personal laundry at home on weekends. A scheduled program of personal hygiene activities was carried out in the dormitories with time allotted for hair shampoos, daily bathing, care of finger and toenails, changes of linen, etc. If possible, residents had haircuts at home.

Students were allowed to lead as normal a life as possible. There were few locked doors. Students were permitted to write and receive mail, and a "penpal" program had been initiated. Telephone calls were freely made and received. Children had spending money, which they used to purchase snacks at the Center. The "token" economy in use for training experiences also provided for small purchases. Students visited the community with volunteers, and were sometimes taken to church on Sunday if they remained at the Center over the weekend. There were no organized religious services. Since all the students attended classes and had organized activities after class, there were only about three hours per day of unscheduled time.

Comments

Of all the facilities visited, GRC Athens Unit seemed to permit the most normal life style. Many factors contributed to this. It had a small population, it served a specially selected group, from a clearly defined region, all students had fully programmed days, and it maintained close ties with the family and community.

The importance of the child's retaining his place in the family and community can scarcely be exaggerated. The policies of the Athens Unit help to preserve this link. Parents are made fully aware of the fact that placement is short-term only; some have even refused services for this reason. Families are asked to take their children home for weekends and holidays, making the program in effect a five-day school. Some students have had to remain at school on weekends because of lack of a suitable family setting or for other reasons, but the staff makes strong efforts to see that all children spend the weekends away from the Unit.

The education and training program should develop into a model for the state. It is closely connected with the Special Education Department of the University, thereby having access to innovative teaching methods and materials. Each student has an individually planned program, devised by a multidisciplinary team; resident students can be programmed on a twenty-four hour basis. The program commands many supportive services not available to most public school special education classes.

Program assistants from the student's dormitories work as aides in the classrooms, giving them an opportunity to see all aspects of the child's function. Hopefully, this will facilitate the carry-over of training from the school to the living area.

In many ways, GRC Athens Unit might be considered a model program from the standpoint of services. However, it is difficult to justify providing residential services for groups whose primary needs should be met in the community. Perhaps the question should be asked: Are these students appropriate applicants for residential services? Could not these services be provided through day programs in the community? Over half the resident students live within the areas originally considered the commuting area. Might not the University place its trainees in day programs as it does in providing many other educational practicum experiences?

If the goals of the University's training programs could be said to include preparation of professional manpower for residential programs, it is still not clear how this can effectively be done at the Athens Unit. The Unit students are certainly not typical of most of the nation's institution populations, which include much larger percentages of severely and profoundly retarded persons.

The Unit should maintain its policy of short-term evaluation and program planning for its students and continue to return them to the community when this has been achieved. Conceivably, pressures from parents might develop which could subvert these goals. For the program to be effective, expanded services must be provided in the school systems of the service area. Often, well designed educational programs developed by the staff for the student can not be effected by the home community. Inability to implement program recommendations has been very frustrating to staff members. In effect, it leaves the program without a rational goal.

The Athens Unit seems to be providing much needed services to its students. It remains for community agencies in the service area to develop the resources needed to complement and complete their program.

GEORGIA REGIONAL HOSPITAL AT ATLANTA

The Georgia Regional Hospital at Atlanta is located in the southern part of DeKalb County, adjacent to the perimeter highway, on rolling terrain which was once part of the Federal Honor Farm. The newly constructed complex, completed in 1967, consists of a number of modern one-story brick buildings which house living quarters for patients, administrative offices, and a cafeteria. Other buildings provide space for supportive services. The buildings are attractive in appearance, air-conditioned and carpeted throughout. The hospital is scheduled to provide services in the following areas: psychiatric-adult, psychiatric-children, alcohol and drug abuse, geriatric, and mental retardation.

Services for the mentally retarded are located in a separate building, which was the first residential section opened in the hospital. There are four thirty-bed units, each unit essentially self-contained, with sleeping areas, activity rooms and dining rooms. Housed in the building are offices for the nursing and clerical staff. There is an attractively furnished reception area.

The Mental Retardation Unit was planned to serve one hundred twenty non-ambulatory patients from a fourteen-county area surrounding Atlanta. It was projected that this population, comprising primarily patients with severe neurological and orthopedic problems, would require a high level of medical and nursing care. A high death rate was anticipated. Living space and program services were planned on this basis. In actual experience, it has been found that only twenty-five percent of the residents require continuous medical supervision and skilled nursing care. These particular patients are grouped in one unit. Many residents thought to be non-ambulatory were taught to walk or use wheel chairs through the vigorous habilitative efforts of the staff. Many have gained independent self-care skills such as toileting, feeding, etc. As a result, the staff needs space for training activities and physical exercise, requirements which were not originally considered. In addition, some residents are thought to be ready to move to more advanced kinds of programs, which are not available except through transfer to the Georgia Retardation Center or to Gracewood.

Admissions

The first admissions to the hospital were transfers from Gracewood and Central State Hospitals. New admissions from the service area rapidly filled the units, and in Fiscal Year 1970 only four residents were admitted. Other than regular admissions, there have been three for crisis care, and one for evaluation. At the time of the visit, there were one hundred twenty residents, about sixty percent male and twenty-six percent non-white. Approximately seventy percent were from the Metro-Atlanta area. Ages ranged from below four to thirty-nine; twenty-five residents were over twenty-one. All were reported to be functioning at severe or profound

levels, although many could not be reliably tested. Residents were grouped as homogeneously as possible, with Units 1 and 2 serving those with more severe problems, and Units 3 and 4 including those with higher functioning levels. No residents had been returned to the community. There had been three deaths.

When a patient is admitted, there are initial evaluations by the pediatrician, social worker, nursing supervisor and dietitian. The patient may later be seen by a physical therapist or orthopedic consultant. Information from this evaluation is available to staff persons working with the resident. Twice a year the patient's total progress is reviewed and changes made in his program if necessary.

Personnel

The Director of the Mental Retardation Program was recruited from the Chaplaincy Service. Although this is an unusual background for an administrator, the program seems to have benefited from the Director's individual and untraditional approach. Some professional departments were understaffed, such as nursing and physical therapy, or not staffed at all, such as education and training. Difficulties in recruiting and retaining RN's, LPN's and attendants have been experienced. The turnover rate has been around fifty percent both for nursing and attendant positions. Reasons advanced for this are the strenuous nature of the job itself and the low salary ranges for attendants.

All personnel are screened before employment by interviews with the Nursing Supervisors or the Director. The applicant is taken on a tour of the facility, and interaction with patients is observed. Initial orientation training and in-service education is provided by Nursing Services. Professional in-service education is scheduled within the various departments.

Medical and Dental Services

Medical services are provided the residents by the staff pediatrician who works during the day shift and provides coverage on a 24-hour basis for emergencies. The doctor makes morning and afternoon rounds, supervises acute cases, and provides routine health care, including physical examinations. The acutely ill resident may be removed to the isolation rooms in each unit, referred to the new medical infirmary unit of the Regional Hospital, or sent to local hospitals if necessary. Consultants in medical specialties are available; an orthopedist is consulted frequently. Residents have been fitted with braces and other orthopedic devices, and surgery needed to correct deformities performed. The hospital pharmacist supervises drug prescriptions which are re-evaluated monthly. One dentist, assigned to the hospital as a whole, gives routine dental care to the patients every four to six months. The nursing staff includes twelve RNs and eighteen LPNs. This service was said to be understaffed at the time of the site visit, especially for weekend coverage, which was at about half-strength. Since there are nearly as many patients on weekends as during the week, the work-load for those who are assigned is doubly heavy.

Treatment Services

Special treatment services, such as occupational, physical, music and recreation therapy, were limited. Although the hospital had an Occupational Therapy Department, no therapist was assigned to the Mental Retardation Unit. A music therapy program was offered in Unit 1 for three hours and Unit 3 for two hours per week. One recreation therapist was assigned to the unit. In physical therapy particularly the program needs were not fully met. A half-time physical therapist and one part-time aide were responsible for services to one hundred twenty residents, most all of whom needed such a program. Only twenty to twenty-five patients per day could be served, and equipment was very limited. In order to stretch the program as much as possible, nursing and ward personnel carried out some of the prescribed procedures.

Education and Training Services

No formal education program had been planned for this unit and no staff positions budgeted due to the nature of its special population. After initial observation, staff members instituted training programs in self-care skills for many of the residents, and had started additional programming for five selected residents. A small area was set up with toys, puzzles and various manipulative materials. Here the psychologist conducted training sessions in basic skills, using behavior modification methods. The program included experiences in auditory and visual discrimination and vocabulary building. Token rewards were given for success in learning. Four residents were enrolled in training programs for the multi-handicapped in the community.

Psychological Services

The psychological services staff consisted of a masters level psychologist and a baccalaureate level technician. The majority of staff time was spent in programming for the residents. They planned and administered the behavior modification program in the units, working with the ward personnel in setting up training procedures such as toileting and self-feeding. Since the initiation of the training program, thirty had been toilet trained, thirty-eight could feed themselves, twenty could dress, forty-two had learned to walk. This was accomplished with patients originally thought to be completely bed-fast. The psychologist also attended staffings for the individual residents and maintained reports of their progress. No intelligence testing or counseling was provided.

Social Work Services

Social Work Services were provided by one social work technician who worked under the supervision of the central hospital staff. In effect, however, she had limited direction from the central staff. Most of her time was spent in administering programs of federal funding such as

Medicaid and OASDI, and in maintaining records. There was little involvement in program planning for the residents. Liaison with community agencies, or involvement in regional functions of referral or counseling received minor emphasis.

Resident Care

The resident living units each consisted of a large central activity room with adjacent bedrooms, a dining room and bathrooms. The area was cheerful and attractively decorated. Residents were observed in wheelchairs, lying on the carpeted floor, scooting or crawling about, or being assisted in walking. Most were dressed in suitable clothing; some wore socks rather than shoes. They appeared clean, neat and well-cared for. Volunteers and Foster Grandparents were seen working with individual residents in various ways, some braiding hair, helping in walking or crawling, entertaining or just talking with their charges.

Each sleeping area had seven beds, most of them the crib or hospital type. Space was provided for resident's clothing and possessions. Toys and stuffed animals were displayed. The bathrooms were adequate, but did not provide privacy. Some children were observed sitting on potty chairs in open areas.

Resident care at Georgia Regional at Atlanta is supervised by Nursing Services. According to the figures given, the attendant-resident ratio varies from about 1/7 to 1/10 for day shifts. An RN and an LPN are assigned to each shift. Foster Grandparents and volunteers are used extensively in the program to provide individual attention for residents. There seemed to be a fair amount of planned activity in progress, particularly in Units 3 and 4 where residents function at higher levels.

Meals were served in the dining room at small tables. Every child who could possibly get to a meal independently was required to do so. Attendants called the residents in to lunch but did not help them initially. Most reached their chairs unassisted although it required some time. Attendants supervised the children during the meal and directly assisted some who were being trained in self-feeding. The food appeared attractively served, and plentiful. Because of the severe physical problems of the mentally retarded patients, the food they ate was not identical to the food served the staff or other patients. Meals served them were ground, minced, chopped, etc. rather than served as in the cafeteria. Meals were planned with this in mind. Special diets for the patients were prescribed by the physician, with adequate controls to insure that the patient received the right diet. Dishes, trays, etc. were washed in the mental retardation unit.

The facility appeared generally clean, although keeping carpeting sanitary was a problem. The rugs in the unit were shampooed weekly with spot cleaning taking place daily. Except for personal clothing, all laundry was sent out to commercial laundries. Diapers were sent to a separate linen company from other linens. Isolation clothing and its cleaning appeared to have the necessary controls to prevent contamination. Eventually, the

Georgia Retardation Center will assume the laundry function.

Residents probably participated in "normalizing" experiences as much as they could. Mail could be freely written and received, and the telephone used by those able to do so. Residents were allowed to visit the homes of volunteers, or go out for short trips if parents gave permission. Visits home or visits from the family were freely encouraged and promoted.

Comments

The visitor to the mental retardation program at the Georgia Regional Hospital at Atlanta is certain to be impressed with the high morale of the staff, both professional and nonprofessional. Due to the patients' extensive physical disabilities, serving them is a strenuous job, physically demanding and time-consuming. In addition, the low functioning level of the majority of the patients makes their progress very slow. In spite of these factors, the staff members who were observed displayed highly habilitative attitudes in the performance of their duties. They seemed to take pride in finding and developing the potentialities of their patients.

The independence of the residents seemed to be encouraged in every way. This was done through diligent attention to self-care training, such as programs in feeding, dressing and toileting skills. It has been possible to remove some patients from tube-feeding programs. In many ways, patients are required to do as much for themselves as possible.

The majority of the patients transferred in to the Georgia Regional at Atlanta had been considered "bedfast" for years, and had developed deformities and contractures which further handicapped them. With very limited physical therapy staff and equipment, many patients have been taught to crawl, walk, or use wheel chairs. In some cases, surgery and special orthopedic devices have been necessary to increase physical mobility.

The professional staff available to plan and carry out programs for these residents was small in number, especially when compared to the number of persons working with the same kind of population in the Therapy Building at the Georgia Retardation Center. However, by making maximum use of the available staff, very creditable results have been obtained. This has been done in spite of a very high turnover rate in attendant and nursing personnel. The hospital has made excellent use of its volunteers and Foster Grandparents. The staff has been able to engender a great deal of community interest in the program.

Although Georgia Regional Hospital at Atlanta is relatively new and fairly adequately budgeted, there are a number of program constraints. There is a need for more space for training programs and physical activities for residents. There should be space for a well-equipped and well-organized physical therapy program. As in most of the newer facilities, the floors are completely carpeted. The time and effort required to keep

carpets sanitary when used by incontinent patients is considerable. Frequent shampooing places large areas out-of-bounds for use during drying time. Perhaps other types of resilient flooring more easily maintained should be considered.

At the time of the visit, Georgia Regional at Atlanta needed additional attendant personnel, nursing staff and professional staff. The AAMD standards recommend a 1:5 ratio for residents of the type served there. Additional attendant staff should make a wider range of activities possible for residents. Children who are eligible for school programs should have such a program provided them, funded by the State Department of Education. The physical therapy staff should be expanded, and necessary equipment made available.

It is unfortunate the the Social Work Services department is not sufficiently staffed to play a larger role as a regional service. Since the families of most of the residents live fairly close to the hospital, there is a great opportunity for increased contact between the institution, the family and the community resources. In addition, the hospital could serve as a resource to nearby communities in areas such as evaluation recommendations, referrals and counseling, and inpatient evaluation.

SOUTHWESTERN STATE HOSPITAL

Southwestern State Hospital, located at Thomasville and Bainbridge, serves both mentally ill and mentally retarded patients. The Thomasville unit, opened in 1966, occupies the site of a former Veterans Administration Domiciliary. In 1967, another unit was opened fifty miles away at Bainbridge at what was previously Lynn Air Base. The Thomasville unit is located in a wooded area on the outskirts of the town. The buildings, of white frame construction, resemble army barracks, consisting of numerous rectangular structures opening off long communication corridors. Much of the physical plant is in bad repair, and extensive renovation has been necessary. However, the grounds are spacious and attractive, and provide a fishing lake. Thomasville's mild climate makes outdoor activities possible year round. There is a large recreation hall and a library.

Mentally retarded patients are served in a unit known as the Rosehaven Nursing Home, a one hundred twenty bed unit for non-ambulatory patients with severe neurological and orthopedic problems. The population of this unit is similar to that of the Georgia Regional Hospital at Atlanta. In addition to Rosehaven patients, three hundred ninety-seven older retardates were served in programs also serving the mentally ill at Thomasville and Bainbridge. The activities of the site visit were almost exclusively in the Thomasville facility, so that the data and observations reported are based largely on its program.

Admissions

When Southwestern was opened, original admissions were by transfer from Central State Hospital and Gracewood State School and Hospital. Transfers included non-ambulatory retarded of all ages, and chronic older patients, retarded and mentally ill. Older residents were selected because it was thought they had potential for functioning in an "open door" setting. Efforts were made to group the mentally retarded in separate living units both at Thomasville and Bainbridge, but no differentiation was made in the program offered them. The goal for this group is rehabilitation and eventual placement in the community.

New admissions are made to the Rosehaven unit from the waiting list. Admissions of mentally retarded to other units are through transfer only. When a new resident is admitted to Rosehaven, a physician sees him for diagnosis and classification. A social history has been made available to the staff by Social Services before admission. The new patient stays in a special admission unit for a few days, and then is placed in the regular Rosehaven units. After this, the Nurse Programmers in consultation with a team evaluate the needs of the patient and plan a program for him. Patient programs are reviewed at regular intervals.

Out of Southwestern's total population of 1,341 patients, 517 (about 38 percent) were classified as mentally retarded. Approximately forty percent were non-white. The large majority of patients of Rosehaven were said to be functioning at the profound level, with a few in the moderate range.

The age range was from four to above forty, with about ninety percent of the population falling below age twenty-one. Twenty-two patients were admitted to Rosehaven during Fiscal Year 1970, from ages four to nineteen.

Personnel

Southwestern is organized as a hospital and directed by a physician. All patient care is administered by Nursing Services. Six RNs and thirteen LPNs were assigned to the Rosehaven unit at the time of the visit. Staff members expressed a need for additional staff; the total hospital needs were expressed as eighteen more RNs and thirty more attendants. Nursing education for the hospital as a whole was provided by a full time staff member, but the Rosehaven unit planned its own nursing education. Orientation and in-service training were provided all staff members.

In employing new personnel, Nursing Services and Personnel Department screened applicants by interviews and checks of reference. All Rosehaven staff have volunteered to serve in this unit. Sixty-five percent of Southwestern's employees were female, and fifty-one percent were over forty.

Medical and Dental Services

Medical services were provided the hospital as a whole by a staff of one part-time and eight full time physicians; one full time and one part-time physician were assigned to the Rosehaven unit. The medical staff rotated to provide twenty-four hour coverage for emergencies. Consultants were available in all specialties: residents needing hospital services were sent to Archbold Memorial Hospital in Thomasville. Each patient had an annual physical examination. Medical rounds were made five days a week by physicians, one of whom was constantly on call. One full time and a part-time dentist furnished dental services to the entire hospital. An initial dental survey was made when a patient was admitted, with periodic examinations thereafter.

Treatment Services

There were no special treatment services assigned to Rosehaven unit other than recreation therapy. There was one occupational therapy aide who served the whole hospital, but was not assigned to the mental retardation program. There was no physical therapy program for Rosehaven despite a definite need for such activities. The nurse-programmers carried on a program which had been developed with the help of a consultant but they were very limited as to resources and equipment. The Recreation Department had a director, two recreation therapists and six recreation leaders. A regular program was scheduled for Rosehaven, about eight to ten hours per week. Twenty to twenty-five residents participated regularly. All who could be moved were taken to sports activities, walks, rides, arts and crafts, cartoons, and special events. Mentally retarded residents of other units participated in the regular program for adults which included dances,

bingo, physical exercise, bowling, crafts, etc. Southwestern had a well-developed volunteer program. Fifteen volunteers served in Rosehaven. Many community organizations have sponsored parties, dances, Christmas presents, and other holiday events. Music therapy, which had a number of music therapy interns, provided many music activities as well as individual music therapy in the living units.

Education and Training Services

An education and training program had not been planned for Rosehaven due to the functioning level expected from the patients. Most were said to be functioning at the profound level and all had severe orthopedic problems due to loss of muscle function and years of being bedfast. However, after evaluating the childrens' behavior, the staff selected some children for a special training program conducted by the nurse-programmers. At the time of the site visit, five students attended for approximately four hours per week; basic skills were taught by the nurse and an aide. Training activities on the ward in various self-care skills were carried on by programmers and ward personnel.

Since programs for the older mentally retarded outside Rosehaven were not differentiated from those for the mentally ill, it was not possible to get exact information as to the number participating in various training activities. Therefore, training programs have been described in general. The Vocational Rehabilitation program conducted classes which served thirty to forty residents over sixteen. Basic academic skills and homemaking were taught them by certified special education teachers. A few residents attended local high school classes and the local technical school.

An extensive Vocational Rehabilitation program was carried on with approximately two hundred residents from Thomasville and Bainbridge. There were ten vocational teachers on the staff. All the older residents are eligible for vocational rehabilitation services, due to the selection factors used in admitting to the program. In practice, referrals come from the coordinators and ward personnel. Estimates by staff members as to the number of mentally retarded in the rehabilitation program varied widely. There were three levels of work training provided. Industrial therapy was open to any patient willing to work, regardless of level. An "employment" agency placed the resident in some type of job in the hospital itself, perhaps in the laundry, cafeteria, library or garage. Residents functioning at lower levels were placed in the unit program where they were assigned chores such as cleaning. The supervisors of all hospital departments had residents assigned to them for whose training they were responsible. These trainees worked eight hours per day, and were paid a small wage. According to a count made at the visit, there were fifty-nine working residents with a diagnosis of mental retardation. If these trainees learned the work routine, were punctual and adjusted well, they were evaluated and placed in a more structured program. The Group Action Program (GAP) was such a program. Three living units were set up, supervised by the residents themselves, representing different levels of competence in independent living. Residents progressed from this program to the regular vocational

rehabilitation program. Here they attended classes, worked in the workshop, or were placed on a job in the community. A number of residents worked in surrounding towns and lived at the hospital at night. If, after six months of this program they are thought to be ready, they may be placed in halfway houses, or stay on at Southwestern and pay room and board. There has been a good rate of success with the placement program, although some have returned because of greater societal pressures in the community.

Psychological Services

The psychology staff at Southwestern included three Masters level psychologists, one with additional graduate work, and two baccalaureate level. No staff member was assigned directly to Rosehaven unit. The psychology staff participated in program planning for Rosehaven patients when requested but had no active project under their direction at the time of the visit. However, they worked actively with the adult retardates in other units, particularly with the Group Action Program and work training programs. By their estimates, a large number of the retarded population excluding Rosehaven could be returned to the community -- possibly eighty percent if good community resources were available.

A member of the psychology staff was a part of the evaluation team which made home visits to applicants on the waiting list. Intelligence testing was done at this time, and also some counseling with the parents regarding good management techniques with the child.

Social Work Services

Southwestern had one of the most effective Social Services observed in the facilities visited. The Department's approach to regional services was well organized and productive. In evaluating applicants for the Hospital Waiting List, a social worker and psychologist visited the home of the child. Due to the large (fifty-two county) service region assigned, teams sometimes traveled as much as one hundred miles on a home visit. As a result of their findings, they recommended priority classification for the applicant, and also tried to help the family to obtain community services. At the time of the site visit, nineteen evaluations had been completed out of fifty-three referred to them.

Since direct admissions were made to Rosehaven, Social Services gave extensive preadmission services including two family interviews, collection of information from the community, and preparation of a social history. This information was made available to the Rosehaven staff before the resident was admitted.

Services to Rosehaven patients themselves were not extensive due to the level of patient function. There was no counseling, and limited participation in program planning. Good family liaison was maintained; a newsletter for families and agencies was distributed. When older residents from other units were placed in the community, Social Services worked with

them extensively in cooperation with public health nurses, Department of Family and Children Services, and the resident's family. There were nine staff members, three of whom were members of ACSW. One Masters level social worker was assigned to Rosehaven.

Resident Care

In Rosehaven Unit

Resident care was organized under Nursing Services. Nurses supervised the various units, and in Rosehaven, nurse-programmers planned all the program activities. The ratio of direct care personnel to residents was about one to eight. An LPN was assigned to each shift, and an RN supervisor for all units. There was a ward clerk assigned to each unit during the day shift.

Rosehaven had three living units, each with forty beds. The living areas were located in long rectangular buildings. The buildings had been renovated, were carpeted and seemed cheerful and attractive. Murals with nursery themes decorated the walls. The beds, which were hospital crib type, were lined up against the wall; the clear areas in the center were used for activities. Children were observed in wheelchairs, lying on the carpets or crawling about, or in their beds.

The residents appeared to be well cared for and most were neatly dressed. An effort was made to dress children in their own clothes, but this was not always possible. The staff reported that the children don't always have enough clothing. There was not enough storage space for each child to have an individual place for his own clothing and possessions. Storage for clean and soiled laundry was said to be too small. Health and hygiene routines seemed to be routinely and adequately performed.

The site visit team did not observe a meal in the Rosehaven unit, but the staff reported the food service to be generally good. Children were fed by attendants or ate in small groups. A number of patients required special diets and specially prepared foods.

"Normalizing" procedures were adequate where they are suitable for Rosehaven population. Residents had full mail privileges, might get incoming calls on the telephone and visit the community if possible. Restraints used were primarily to maintain body position or to prevent self-destructive behavior. Religious services were provided on Sunday and for prayer meeting. The Chaplaincy Service had a weekly group meeting for those residents capable of participating.

Staff members estimated that about sixty percent of the Rosehaven residents' daily time was programmed. Each patient had a nursing care plan; efforts were being made to plan training activities for all. At the time of the site visit, twenty were in toilet training programs and sixteen in feeding training. Those in the special training unit had more activity

programmed than the other patients. Residents were taken outside as often as possible for fresh air and stimulation.

Resident Care

In Other Units

Since the visit to Southwestern was confined primarily to observations of the Rosehaven unit, the team saw less of the program for older retardates. Like Rosehaven, these resident care services were supervised by Nursing Services. Mentally retarded residents were said to be grouped in four of the units. About a 1/17 staff attendant ratio was maintained in these units, which was said to be too low. Very few residents were observed in the living areas, since most were out on work assignments. These residents ate in a large cafeteria, which was being remodeled at the time of the visit. The team observed them being served at a temporary cafeteria in another area. The food was plentiful. Older residents seemed fairly neatly dressed and groomed, although many had the appearance of long-term institutionalization. Clothing could be selected from a store which had both new and used garments. Toilet articles, grooming accessories and other small items were available there.

The life style observed at Southwestern demonstrated many normalizing factors. No locked doors were observed. Older residents seemed to be very much self-directed and had a great degree of freedom. Most were engaged in constructive activity, and had little idle time. Of course, they had been especially selected for this setting. Those who cannot conform must be returned to Central State or Gracewood.

Comments

Southwestern State Hospital, despite very poor physical facilities, has developed an excellent rehabilitation program. This has been accomplished through the efforts of a highly motivated staff with progressive ideas. Much credit must go to the leadership given by the Superintendent and the professional staff. The original residents transferred from Central State and Gracewood included older mentally retarded and mentally ill persons who had been in institutions for many years. The training in work skills and independent living received at Southwestern has enabled many of these persons to return to the community, to be gainfully employed and to become contributing members of society.

The residents at Southwestern, particularly the older ambulatory patients, appear to have a busy, productive life. Very little of the "sitting around" or aimless, stereotyped behavior often seen in long-term residents is observed. The living areas, while scarcely luxurious, seem to be adequate and comfortable. Above all, the freedom of movement and absence of locked doors produces a much more "normal" life style.

In the Rosehaven Unit, the staff has been alert and responsive to the needs of the residents. The nurse-programmers have done a commendable job of initiating and implementing training programs, with a very small professional staff.

The Rosehaven Unit needs space, equipment and personnel for additional training activities. The staff-resident ratio is low for patients of this category, being about 1/8 rather than the 1/5 recommended by AAMD standards. There is a definite need for an organized physical therapy program providing necessary professional staff, technicians and equipment.

The buildings of the Thomasville Unit are old, in need of extensive renovation, and in many ways unsuitable for the program. A very small portion of the area is air-conditioned. It is questionable, however, if additional investment in the physical plant can be justified.

The Social Services Department gives excellent services to the families of children admitted. There is extensive pre-admission contact, and good liaison is maintained. The outpatient evaluations for the waiting list applicants in the service region are of great help to families who formerly had to travel to Gracewood for this. The addition of a pediatrician to the team, scheduled for the fall of 1971, will allow a much more thorough evaluation. Perhaps the psychological testing of children in their homes with all the attendant distractions should be studied with respect to efficient use of professional time. An alternative might be to schedule psychological testing in local health departments.

In general, Southwestern seems to offer an effective program for the two specialized groups of mentally retarded persons served.

MULTIPURPOSE RESIDENTIAL FACILITIES

CENTRAL STATE HOSPITAL

GEORGIA RETARDATION CENTER

GRACEWOOD STATE SCHOOL AND HOSPITAL

CENTRAL STATE HOSPITAL

Central State Hospital is located on the outskirts of Milledgeville in Central Georgia. The facility is almost a town within itself, with its own water supply, fire department and large medical-surgical hospital. Situated on a campus of 1,000 acres, it has 135 buildings, 24 of which provide living quarters for the residents. It is Georgia's oldest mental health facility, having been opened in 1842.

It is not known exactly how long Central State has been serving the mentally retarded; however, it is probable that there have always been mentally retarded persons in its population. Up until 1965, there were no differentiated programs for retarded persons. They were distributed among the wards for the chronic mentally ill, with children and adults more or less indiscriminately mixed. In 1965, in response to public pressure, an effort was made to separate the mentally retarded from the rest of the hospital population. Most of the children were placed in the Boone and Boland Buildings, and a separate program, Unit IX, was set up for them. However, there remained in the units for the mentally ill a substantial number of older retardates.

Since the organization of Unit IX, retarded applicants under twenty-one are admitted there. Those over twenty-one are placed in the units primarily serving the mentally ill. Each of these units serves patients from a certain group of counties; hence the term "geographic unit." At the time of the site visit, seven hundred sixty-one residents were being served in Unit IX. Over one thousand retarded residents were served in the geographic units.

At one time the total resident population at Central State was almost thirteen thousand. By 1970, it had been reduced to approximately nine thousand, due to improved treatment programs which return more patients to the community, and to transfers into the new regional hospitals and into nursing homes. Although Central State has made much progress in reducing its overcrowding and upgrading its services, it is still funded at the lowest level of any state mental health facility. The per diem cost of $9.76 for Fiscal Year 1970 was the lowest of any institution in the state.

Admissions

Central State admits retardates of all ages and levels, and serves the whole state. During FY 70, one hundred and one persons all under twenty years of age were admitted to Unit IX. A total of three hundred fifty-six were admitted to the geographic units; of these, two hundred fifty-four, or seventy-one percent, were over twenty-one years of age. Separation statistics cover Unit IX only. Ninety-seven residents left the program; four were discharged, sixty-eight transferred, and twenty-five died. Since 1967, one hundred three patients have left on convalescent leave. The only outpatient services performed are evaluations for the waiting list, and occasional genetic counseling.

After the patient is admitted, a physical examination is given within the first twenty-four hours. About one month later, a staffing is conducted, at which time the patient's program is discussed. Attendants do not ordinarily attend staffings. On special referrals, patients may be re-evaluated at a later date.

Personnel

Central State was short-staffed both in the professional departments and in direct care personnel at the time of the site visit. Unit IX is organized entirely on the medical model. All resident care is administered under Nursing Services and the unit director is a physician. The direct care staff is selected by the Nursing Director and the Administrator through interviews, and psychological testing if necessary. Attendants are given written examinations. About forty percent of the staff are over forty years of age and seventy-seven percent are women. There are fifty-seven paid working residents, most functioning in the mild and moderate range.

In the past, training for Central's direct care personnel has been largely informal and on-the-job, and has consisted primarily of teaching basic nursing skills and personal care of residents. The orientation of the hospital-provided training was toward psychiatric nursing. A program of clinical instruction has been recently initiated, which will combine some lecture or classroom instruction with practical training on the ward. The curriculum includes basic information about mental retardation, an explanation of the treatment program and discussion of treatment philosophy. This should result in a more appropriately trained staff.

Medical and Dental Services

At the time of the visit, medical and dental services were provided by a staff of six physicians, five of whom were foreign medical graduates. Physicians were on call to provide twenty-four hour coverage. Daily ward rounds were made by staff physicians, who gave regular physical examinations and provided routine health care. Medication programs were supervised by the physician and pharmacist, and were reviewed every two months. If necessary, consultants in all specialties were available. Acutely ill residents could be put in isolation in the wards, or if necessary transferred to Jones Hospital, the medical-surgical unit. A dental survey was done once each year and necessary treatment provided.

Treatment Services

Special treatment services were quite limited. The Occupational Therapy program was staffed by six occupational therapy aides who worked with eighty-five mentally retarded residents. The program was housed in a large ground level room which contained crafts materials. The team observed older women engaged in sewing and embroidering.

No physical therapy services were provided the over two hundred non-ambulatory residents. Plans call for a physical therapist and two aides for the Medicaid units which receive additional funding from federal sources. However, at the time of the site visit, none had been employed.

Two recreation therapists and two leaders were assigned to provide services for Unit IX residents. All residents were served to some degree, but programs were very limited in the wards for low-functioning patients. Some additional recreation activity was supplied by the re-motivation teams, and music therapy personnel. Staff members expressed an interest in getting selected residents into local community recreation programs, particularly for swimming. Evening and weekend programs were provided, usually for special events.

The music therapy department at Central State has engaged in several innovative resident training programs. Several projects concerned with how music affects behavior have been set up under controlled research conditions, and data has been collected. Songs, musical games and music rewards have been used to teach toilet training, feeding, other self-help skills, and simple commands. In some programs, basic concepts and academic skills have been taught through music. One music therapist, a part-time aide and part-time researcher provided the regularly scheduled program at the time of the visit. Traditional music activities included a choir which sang for church services. Staff members felt that much more might be accomplished with additional staff, some special equipment, and quiet places in the wards for activities.

Education and Training Services

Education and training programs at Central State were housed in an improvised school area in the Boland Building. There were eight EMR classes and six TMR classes serving approximately one hundred thirty children. Basic teacher salaries were funded by the State Department of Education. Children were selected for the program by the principal from a list of recommendations from the psychologist and social worker. Staff members expressed a need for better physical facilities for the school program, as well as additional classes and teachers. They stated that it was difficult to teach the residents when the wards did not provide a suitable environment for homework and study. The classroom provides the only setting for learning. In order to prepare these students for community life, both school and living environment must be improved. There is a need for speech therapy and a language development program.

Vocational Rehabilitation services at Central State were provided both the mentally retarded and the mentally ill. A counselor was assigned to the Boone and Boland Buildings. Mildly retarded persons, screened by the counselor, were served in the Yarbrough Building which provided both residential and workshop services. Approximately forty trainees were enrolled in this program. Evaluation usually lasted four to five days, and the work adjustment program was carried on in a sheltered workshop on the campus.

Six clients were considered ready for community placement at the time of the site visit. Clients might possibly be placed in a halfway house for a limited time, but no follow-up services were available once a client entered the community. There were fifty-seven working residents who were paid small wages for their work in the institution. Needs expressed by the staff concerned the lack of foster home placements in the community, as well as the limited services available to the fourteen to sixteen year olds.

Psychological Services

Psychological services were provided by one Ph.D. candidate, three Masters level, and four Baccalaureate level staff members. Intelligence testing was provided, and re-evaluations on referral. Evaluations were also done for waiting list applicants on an outpatient basis. Psychologists sometimes counseled residents informally, but on a very limited basis. Perhaps the psychology department's most active involvement was in programming for the residents. Staff members served as unit leaders in wards, where they initiated training programs using behavior modification techniques.

Social Work Services

The Social Services staff consisted of one MSW and three Baccalaureate level technicians. The average caseload was two hundred residents. Pre-admission evaluation was given by a team on which a social worker served but there was no continuing family counseling. Social Services was attempting to develop, together with vocational rehabilitation, a program of community placement. It was felt that perhaps forty percent of the present residents might be served in the community if a full array of services and living settings were provided. Liaison work with the family and community was limited; approximately two hundred eighty residents were never visited by their families.

Resident Care

Mentally retarded residents of Central State Hospital were housed either in Unit IX Buildings, the Boone and Boland Buildings, or in the geographic unit serving their county of residence. Statistics for Fiscal Year 1970 showed that over one thousand residents lived in the geographic units, and seven hundred sixty-one lived in Unit IX. The team visited all the wards of Unit IX and several Wards in the Powell Building serving residents from the metropolitan Atlanta area.

The Boone and Boland Buildings were built in 1952 and 1953 respectively, and were assigned to the mental retardation unit in 1965 when the first movement began to separate the mentally retarded from the wards serving the mentally ill. They are one story brick buildings located adjacent to each other. Female patients and some young males were served in the nine

wards of the Boone Building; male patients were served in five wards of the Boland Building. Although the population of these two buildings was below the stated capacity of nine hundred four, the general impression was clearly one of overcrowding.

A typical ward in the Boone Building was entered through a locked door framed by heavy metal screening. A large corridor-like room served as a day room. The day rooms were sparsely furnished, containing some benches, chairs and tables. Very little play or activity materials were observed, particularly in the wards for severely and profoundly retarded. Opening from the day room were large dormitory-like sleeping areas with rows of beds lined up against partial partitions. There were some wall decorations, but in general the surroundings were bare and unstimulating. Group bathrooms served the sleeping areas. The Boland Building was similar to the Boone Building, with large congregate wards, day rooms and sleeping areas.

A ward serving sixty severely and profoundly retarded girls and women presented a most depersonalizing and unstimulating environment. The residents were seen sitting or lying on the floor, lined up on benches or wandering aimlessly. They were dressed in ill-fitting drooping "institution" clothing, many in hospital gowns. Most were barefoot. Some were in various stages of undress. Many exhibited scratches, bruises and other skin abrasions. Since many were incontinent, there were unpleasant odors. No programmed activities were observed in this ward. Five attendants were assigned to provide all the personal care for sixty profoundly and severely retarded persons; by AAMD standards, twelve attendants are required.

Some of the wards had better staffing patterns, due to the availability of Medicaid funds, or the increased nursing requirements of the residents. Boone 4, serving young children with severe physical handicaps had six attendants for fifty-eight residents, plus an RN. The two Medicaid wards, Boone 6 and 7, had staff ratios of 1/8 and 1/10, and in addition had two RNs and two LPNs assigned to the day shifts. The increased staffing was reflected in a greater level of resident activity, and more interaction between staff and residents. In general, however, there was a severe shortage of direct care personnel. Comparison of staffing patterns with recommended AAMD staff ratios is shown in Appendix G.

Meals for some residents in the Boone Building were served in a large cafeteria, with tables seating six to eight. Food was brought from the central kitchen and served from a serving line in the cafeteria. Special diets were prepared in disposable trays for individual residents. The food was plentiful, hot and adequate. Staff and residents all ate the same food, prepared in a central location.

In general, residents appeared poorly dressed, unkempt and ill groomed. Apparently, unless a resident was able to take some responsibility for his own clothing, separate personal clothing supplies were not maintained. Staff members expressed preferences for "common" clothing for the severe and profound who require many changes and can not take care of their own clothing. Evidently clothing was sorted by sizes and shared in common by

the residents. In answer to questions regarding lack of shoes, staff members indicated that is was not possible to keep shoes on residents who continually remove them. Many residents have all their clothing supplied from the stock of "state clothing." Numbers of male patients wear a two-piece work uniform of heavy cotton. Some of the resident's personal clothing was kept put away for use when the patient has visitors or goes home for a visit.

Although the staff at Central State was trying within its resources to improve programming for Unit IX residents, the visitor's general impression was of large numbers of residents with little or no activity. This was particularly noticeable among the severely and profoundly retarded. A TV set might be operating, but residents appeared to be paying little attention. Staff members said that many residents had less than two hours of programmed time per day, and scarcely ever left the wards. Much stereotyped behavior, such as rocking, finger shaking, pacing, etc. was observed.

The different professional departments operated programs in assigned areas, but were limited in the amount of time they could program because of lack of staff. In addition, programs were not uniformly available to all residents. Ward activities were planned by unit leaders from the various disciplines, and included behavior modification, music therapy, re-motivation and recreation, and occupational therapy. However, at the time of the visit, there were only twenty staff members in all these departments to provide services for nearly eight hundred residents. Limitations in programmed time were easily explained due to the small number of professional staff.

All wards were locked, as were other doors between building sections. It was impossible for a resident to go about the building freely or unescorted. Privacy, or personal possessions were practically impossible. "Isolation" rooms and restraints were in use. Attendant time was taken up with ward duties with very little time available for interaction with the residents.

Team members visited the Powell Building, in the geographic unit for metropolitan Atlanta. Built in 1858, the Powell Building has been renovated and looks clean and freshly painted. Residents have semi-private rooms, and share a common day room. An Atlanta resident assigned to the geographic unit was awaiting transfer to a mental retardation ward. He was placed in a locked day room containing twenty-five or more older psychotic persons. All were dressed in tan uniform "state" clothing. Many were barefoot, lying on the floor of the day room. A TV set was flickering on the wall. No other activity was evident. A ten year old mentally retarded boy was assigned to a unit with mentally ill men. This child was allowed to stay in the office with the charge nurse for much of the day because of lack of an appropriate program. Mentally retarded children admitted to geographic units must wait for transfers until Unit IX has vacancies.

In some ways, resident living conditions in the Powell Building were preferable to those in Unit IX. Residents had semi-private bedrooms, and the hallways had more comfortable sitting areas. However, such programs

as were available for the mentally ill were essentially inappropriate for the mentally retarded. In addition, mentally retarded persons, both adults and children, were often unable to protect themselves from exploitation by other, more able, patients.

Chaplaincy Services

Chaplaincy Services seemed to be well organized with special programs for both childrens' programs, Units VIII and IX. Worship services were conducted in the chapel on Sunday and Wednesdays, as well as in some of the wards. The Chaplains visited the wards regularly, talking with the residents and sometimes counseling those specifically referred by staff members. Families were seen for pastoral counseling when needed. On the occasion of the visit, the Chaplain was observed counseling a family who had brought a child to be admitted. Chaplains attended staff meetings and furnished reports if necessary. A number of seminary students were assigned to the units.

The religious programs offered the residents some contact with community groups and also enabled these groups to learn more about the Central State program. Occasionally visiting church groups were offered orientation by the Chaplains; such groups sometimes conducted direct activities with residents.

Comments

With the lowest per diem cost of any state institution ($9.76 in 1970) Central State Hospital appears to have the highest level of need. Central State needs everything - more professional staff, more direct-care staff, more planned programming for residents, better living areas, better outdoor space.

All other mental health facilities in Georgia enjoy a higher level of funding than Central State. The new regional hospitals have costs of around $31.00 per day; the two training institutions, Georgia Retardation Center and Georgia Mental Health Institution, have costs of around $33.00 per day. Central State's low budget might be more understandable if the hospital served a small population, or admitted patients with the least serious problems. In fact, however, Central State serves approximately forty percent of all the mentally retarded in Georgia's institutions, and approximately three-fourths of the hospitalized mentally ill of the state. The hospital population includes a large proportion of long-term or chronic patients, the criminally insane remitted by the courts, most of the mentally ill with serious medical problems such as tuberculosis and diabetes, and mentally retarded juvenile delinquents. All of these groups present problems of great severity requiring specialized treatment methods. In addition, many of these patients are committed by county officials with very little screening or previous treatment. In the past, the hospital has served as a dumping ground for deviant individuals of many types. In view of these facts, it is very hard for the interested layman to understand why the administrative and professional staff, and the programs at Central State are

funded at a level so much below that of other institutions. They have the patients. They have the problems. Why don't they have the money to do the job?

Considering the treatment tasks facing them, and the small resources available, the hospital staff members must be commended for their efforts to deal with these problems. Every department is short staffed when judged by standards applied to Georgia's other facilities; some essential services are totally lacking. Yet the staff as a whole seems to be making continuing efforts to improve services for as many residents as possible. Innovative training programs developed by the psychology and music therapy departments have shown that the residents can learn and may be trained to function better if adequate personnel and facilities were available. The Education and Training staff, in improvised housing and short hours, tries to improve the functioning of selected residents, but has no mechanism for carrying over this training to the living units. Recreation and remotivation teams with limited personnel stretch their services as much as possible. The nursing and attendant staff have such large numbers to care for that only the most basic custodial services can be given them. They have little time available for training residents, or interacting with them. Training programs initiated by the professional staff are often not reinforced in the wards.

In addition to lack of staff, the program must be conducted in highly unsuitable, abnormal and dehumanizing living areas. The large, bare unattractive day rooms and dormitories make privacy impossible, and present very poor settings for any kinds of organized activities. There is very limited equipment available for use in such activities. Some of the living areas are in very poor repair, with cracked and peeling paint, and pervading unpleasant odors. All ward doors seemed to be locked, as well as outer doors. Immediate attention should be given to improving the living areas so that something approaching a more homelike setting may be achieved. Major interior renovation is needed to provide smaller, more private activity and sleeping rooms.

The visitor is impressed by the large numbers of residents who appear to have no constructive activity. The programs that are being conducted by the staff reach only a very few at a time, leaving many patients without any observable program. Much stereotyped behavior, believed to be the result of inactivity, is observed.

The efforts of Central State staff members are to be commended, but they need help in many areas before an effective training program can be provided to the residents. The State of Georgia must insure that they receive this help in the form of improved living space, equipment, materials and staffing.

GEORGIA RETARDATION CENTER

The Georgia Retardation Center is located in a pleasant suburban area of north DeKalb County on wooded, rolling, beautifully landscaped acreage. The first phase of construction, completed in October 1969, includes the Administration Building, the Therapy Building housing non-ambulatory students, five cottage residences for ambulatory students, the Theater Building, Community Center, Power Plant and Maintenance Building. The attractive red brick buildings are air-conditioned and carpeted throughout, well equipped and tastefully furnished.

The Georgia Retardation Center was designed to be Georgia's primary training and research unit in the field of mental retardation, in addition to providing treatment services to one thousand retarded persons from all over the state. The first construction phase provides beds for four hundred eighty students. The remaining five hundred twenty beds are planned for future construction. Sites for future buildings have been prepared; present supportive and maintenance services can be expanded to serve the planned construction.

Admissions

Admissions began in October 1969; by the end of Fiscal Year 1970, one hundred sixty-four students had been admitted. The first students entered the non-ambulatory units of the Therapy Building. In February 1970, the admission of ambulatory students into the cottages began. In all, seventy-two students were transferred from other facilities, and ninety-two accepted from the waiting list during FY 70. There were nine temporary placements. Admissions have continued at the rate of twenty or more per month. By October 1970, there had been four separations. At the time of the site visit, outpatient services were limited to the early childhood education program serving approximately twenty, and social services such as referral and counseling.

Admission procedures include an initial physical examination and social summary completed within the first twenty-four hours of residence. Within the first two months, each department evaluates the new student. The results of these evaluations are shared and discussed at a case staffing attended by cottage personnel and professionals. At the time of the visit, no psychological evaluations were provided. Estimates of the students' level of function were based on application information, and the doctors' and other staff members impressions. The results and recommendations of the case staffing are available to all personnel concerned with the students program. Students are re-evaluated and programs are reviewed whenever necessary, depending on the individual's progress.

Personnel

At the end of FY 70, the Georgia Retardation Center had employed five hundred forty-four staff members of all levels. As a new facility, the administration had experienced difficulties in recruitment in some areas. At that time, no directors for Medical, Psychology or Speech and Hearing Departments had been employed. Problems of recruiting professional staff were ascribed to non-competitive salary levels set by the State Merit System and the general shortage of well trained professionals in mental retardation. Difficulties in recruiting non-professionals were laid to lack of public transportation and the distance from the central city. Turnover in this personnel has run around thirty percent. A majority of the "program assistants" (the job title of attendant personnel) were said to be college graduates. Although no statistics were supplied, most employees were observed to be younger persons, the majority females. New employees were screened through interviews with the Personnel Director; the use of a skills inventory in employment procedures was said to be under consideration.

The staff development program is administered by a training director. Program assistants have a two-day orientation program in which they follow selected students through the day's activities, attend panel discussions, etc. Orientation at the professional level is individually planned and includes visits and field experiences. Continuing education is the responsibility of the direct supervisor of the cottage personnel; each professional department has a member assigned to plan training activities.

At the time of the site visit only eight students had work assignments. Policy statements prohibited the use of students as substitutes for regular employees, or to provide basic services. Work assignments were seen primarily as training and social experiences.

Medical and Dental Services

Medical services were provided by a staff of three full time physicians and two one-fourth time, all of whom were board diplomates. Consultants in all specialties were available to the institution. Contract arrangements with Northside, Egleston and Emory Hospitals afforded services for those in need of acute medical and surgical care. In addition, there was a twenty bed unit in the Therapy Building for the acutely ill resident; ten beds were available to the present population. All students had annual physical examinations and routine preventive procedures such as immunizations. Physicians made daily rounds in the Therapy Building. These non-ambulatory students were staffed every three months. The Pharmacy Department, including two pharmacists and one clerk, administered the drug program. Drugs were prescribed by physicians and dentists, and prescriptions were limited to a maximum of 180 days.

There was a large, well-equipped dental clinic staffed by three dentists and a dental hygienist. Routine dental care was scheduled for all residents. Outpatient services were also planned in the near future since the department had the capacity to serve eighty-five residents and fifteen outpatients each week.

Medical records were supervised by a registered Record Librarian who had at her disposal an elaborate computerized system. There was a well-equipped and well-staffed medical laboratory.

Thirty full time and six part-time RNs, thirty LPNs and one hundred twenty program assistants were employed by Nursing Services. The turnover rate in this department was said to be very high. In addition to the nurses administering the program in the Therapy Building, there was one nurse assigned to each cottage during the day, and one to the clinic.

Treatment Services

The Occupational Therapy staff worked both individually with students, and in consultation and training functions with program assistants and other staff members. An initial evaluation was done for each student soon after admission, and program plans made for him. At the time of the site visit, staff members were working individually with thirty-seven students per day, and evaluating eight to twelve per week. The staff included a director, two full time and two half-time registered OTs. In addition there were two OT aides and a typist. Since there were music and recreation therapy departments, the occupation therapy department served in other areas. Programs for students included training in such self-care skills as feeding, dressing, etc.

The Physical Therapy Department employed a director and three physical therapists, all registered, and three technicians. Initially, a large portion of staff time was spent in evaluating students. Forty-five students were receiving daily therapy services, although there were said to be sixty in need of this treatment. The department was well-equipped, with all necessary facilities, including a pool.

Recreation services were provided at GRC to all students, regardless of the degree of handicap. This department also provided physical education instruction to the TMR classes. Activities offered were planned for educational as well as therapeutic values. Profoundly retarded students in the Therapy Building were scheduled for activities stressing sensory stimulation, movement patterns, experiences with color. Simple pool activities were also planned for this group. Wheelchair students had more varied activities, such as arts and crafts, group games, day camping, play with educational toys.

Cottage residents were scheduled for bowling, swimming, ball games, and playground activities. Structured physical education activities were also planned four hours per week. Staff members included the director, three therapists, three recreation leaders and a secretary. Individual staff members had expertise in physical education and arts and crafts. Shifts were staggered so as to provide some night activities and special activities for weekends. The usual special events such as holiday parties, dances and weekly night parties were provided. Staff members expressed needs for more indoor space for recreation activities, such as a gymnasium and swimming pool. They would like to integrate selected students into community recreation activities, but feel students need preparation for this.

The Music Therapy Department had a director, three music specialists who had a music education background, one music therapist and two music associates. The music program stressed the total development of the child and tried to improve speech development as well as developing basic music concepts. The students learned through active participation in music activities. The Therapy Building music program was scheduled both morning and afternoon for small groups of students. Cottage students participated in activity room programs; those who attended the TMR classes had additional daily music programs.

Education and Rehabilitation Services

In the architectural and program planning for GRC before its construction, it was proposed to obtain educational programs for those students eligible for special education classes from the local school systems. A tentative agreement to this effect was worked out between the GRC superintendent and the superintendent of a local system. Therefore, no actual classroom space for residents was constructed. Unfortunately, this agreement has not as yet been implemented. It has been necessary to improvise space and employ staff for education programs on the campus.

The first program initiated was the Early Childhood Education project which at the time of the site visit served twenty-two children, twenty outpatients from four surrounding counties and two residents. Among the program objectives were the development of individualized curricula, the development of training techniques, and involvement of parents in the children's training. The program was housed in the Theater Building and was operated for three and one-fourth hours per day.

Fifty-five non-ambulatory students from the different units of the Therapy Building were taught individually or in small groups in areas set aside for this purpose. Most of these students functioned in the severely and profoundly retarded ranges. They received from two and one-half to five hours per week of instruction.

Fourteen students with motor handicaps, most in wheelchairs, were enrolled in a training program stressing academic skills. A pilot project called the Interdisciplinary Team project was provided for seven students, ranging from low moderate to severe level.

Of the cottage students, five were attending classes in Fulton County Schools. Thirteen were enrolled in two TMR classes located in the activity rooms of an unoccupied cottage. This program offered four hours of instruction in a typical TMR core curriculum. The team observed activity in which a teacher from the music department taught the names and sounds of several different instruments. One supervisor, two teachers and a trainee staffed the TMR program.

Staff members said that they needed more space to house programs and funds to hire teacher aides. If plans to enroll more students in local school programs materialize, additional funds for transportation will be needed.

Vocational Rehabilitation Services were not formally available as a part of GRC services at the time of the site visit, although two students were attending the Atlanta Evaluation Center. A student work coordinator had been designated to supervise the on-campus work training of eight older students.

Psychology Services

A Director for Psychological Services had not yet been recruited at the occasion of the site visit. Therefore, no on-campus psychology services were offered.

Social Work Services

The Social Work Department when fully staffed will employ three associate directors for Services, for Training, and for Research, under the Department Director. At the time of the site visit, the Services Division had two Chief Social Workers assigned to inpatient and outpatient services. The Associate Director for training had been recruited, and one second-year graduate student was placed in this division. The total staff consisted of the director, three employees who are members of ACSW, three employees with MSWs, and two with Baccalaureate degrees.

Pre-admission services included contacts with families to help them understand the policies and programs of the Center, and to help prepare them for separation from the children. After admission, the department maintained liaison with parents through letters, telephone calls and interviews. Services concerned with return of students to the community, on furloughs or a permanent basis, were just beginning.

The department participated in program planning, particularly in the Community Living program. When indicated, there was limited individual counseling with students.

Outpatient services included counseling related to the admission process, and some work with parents and agencies from the community seeking advice or referrals. The Georgia Retardation Center plans to make waiting list evaluations similar to those done at Gracewood. Due to the fact that no psychological services were presently available, these services were limited to home visits by the outpatient division. The home situation is evaluated and recommendations made to Hospital Admissions as to priority.

Resident Care

Students at Georgia Retardation Center were housed in either of two types of settings depending upon their functioning. Students admitted to the Therapy Building, administered by Nursing Services, were selected from multi-handicapped, non-ambulatory applicants. Ambulatory students of all ages and levels of function were admitted to the Community Living

Program which is housed in five cottages. At the time of the site visit, only two cottages, 15 and 17, were occupied.

Therapy Building

The Therapy Building housed office space for the professional programs, the central kitchen and laundry, as well as living space for the non-ambulatory students. The living areas were modern, spacious and comfortably furnished. There were attractive wall decorations, and play materials were in evidence. Sleeping areas for the most severely physically handicapped had ten beds each, which were pushed back against the walls during the day. Bathrooms, while not completely private, were curtained in some areas. The students appeared well cared for and were neatly dressed in everyday clothing, wearing socks when it was not possible for them to wear shoes. Those unable to sit in wheelchairs had been taken from their beds and placed on mats on the floor. Members of the staff were engaged in various activities with the students.

Thirty-five residents in wheelchairs had semi-private sleeping areas with adjoining baths. Space was provided for clothing and personal possessions. A comfortable activity room adjoined the sleeping areas, with TV and various activity materials available. The wheelchair students, who generally seemed to be functioning at higher levels than the completely non-ambulatory, had considerable freedom of movement about the various areas. No restraints or "isolation rooms" were used.

An excellent staff-resident ratio was maintained in the Therapy Unit. In the non-ambulatory units, there were four program assistants for each twenty students during the day shift, plus one RN and one LPN, providing a 1/5 ratio. Records were maintained by a ward clerk. In the wheelchair unit, there were six program assistants assigned to forty students, providing a 1/6.6 ratio. An RN and a ward clerk were also assigned to this unit.

Meals were served family style at small tables in the dining area. The food was plentiful, hot and attractively served. Staff members circulated among the students to assist them when necessary. In an adjoining area, members of the occupational therapy staff assisted individual students with whom they were working on feeding skills. Modified eating utensils had been designed to enable them to eat independently. Staff members seemed to regard the lunch period as a training opportunity. Some of the more severely handicapped required special diets and feeding procedures which were prescribed by a physician.

Students in the Therapy Building seemed to be included in programming by all the professional disciplines, and participated in as many activities as possible. One of the staff members pointed out an activity schedule for one of the wheelchair patients which programmed twelve and one-half hours out of the unit each week. In addition, there were unit recreation activities over the weekends, and special events. In view of the extensive physical limitations of the students, there seemed to be a wide variety of training and leisure time activities.

Community Living Program

Ambulatory students lived in the cottages, which are two-story brick buildings. Dining and activity areas are on the ground floors, with sleeping areas and reception areas above. These buildings are attractive, air-conditioned and comfortably furnished. Carpets are used throughout. Students of cottage 15 and 17 had semi-private bedrooms, with group bathrooms. The bedrooms were attractively furnished with ample space for clothing storage and personal possessions. Students could display their family pictures, souvenirs, etc. on the wall or bulletin boards. While there were girls and boys in each cottage, sleeping areas were separated.

The students in the Community Living Program made up an extremely heterogeneous group, including all ages, levels of function, and types of behavior. Staff members said that selection of this method of grouping was based on a rationale which holds that such groups more nearly simulate family groups and allow beneficial interaction between individuals.

Activity rooms were adequate in size and contained a good selection of varied play materials. Meals were served family style in the dining area. Food was plentiful, hot and attractively served. Members of the cottage staff ate with the students. Generally, the children appeared neatly dressed in their own clothing and shoes. About half the students need to have some clothing furnished by the institution. Staff members said that problems had been experienced with the laundry, such as tearing clothes, losing them, etc. When the institution must furnish clothes, the Director of Community Living makes efforts to select clothing which is not "state furnished" in appearance. A shoe and clothing store is operated on the campus where students may select clothing.

At the time of the site visit, students in cottages had limited programmed activities, particularly the over-fourteen group. Thirteen of the younger children attended classes on campus, but there were no training activities for those over fourteen. Since the visit, other activities have been developed with consequent improvement in programming. Most students now are reported to be out of their rooms attending various programs from 9:00 a.m. to 2:00 p.m., excepting the lunch period. In the afternoon, play outside or possibly physical education is scheduled. The goal is eight hours of programming for each student per day. Newly developed activities are: a work program for older students, an early learning center, and an industrial arts program. Some evening programs such as sewing classes, family night, etc. have been initiated.

The Community Living Program maintained a very good staff-resident ratio of 1/3 during the day shift. Each cottage had a program administrator who lived in the cottage, supervised the program and was on duty at important times during the day such as getting up, meal times, bedtimes. This provided a much needed "continuity" of personnel. Of the direct care staff, about forty percent were "program specialists," a higher-level position requiring a college degree. Program assistants (attendant level) made up the rest of the direct care personnel. An interesting advocacy system had been organized within the cottage staff. Each student had a

"chairman" among the staff members whose duty it was to promote his interests and act as a parent-surrogate.

Residents could receive mail; many had signed up for "junk" mail and enjoyed receiving it. They could telephone home on a planned schedule. Spending money could be carried or obtained from student's accounts to make purchases at the canteen or community shopping centers. Students visited the community for shopping, bowling, etc. Bedtime and arising times were flexible; students could sleep late on occasion and have a cold breakfast. There seemed to be maximum staff contact with residents, as there are no congregate wards or large activity rooms.

At the time of the visit, no organized religious or chaplaincy service was available. However, the campus has a handsome chapel in the theater building which may be used for religious services. Groups of students visit community churches from time to time.

Comments

Georgia Retardation Center doubtless has the greatest potential of developing an excellent program of any of the state's mental retardation institutions. This results from superior physical plant and equipment, large professional staffs in all disciplines, and high levels of funding. GRC's per diem cost in FY 1970 was $33.20, about four times that of Central State Hospital and two and one-half times that of Gracewood.

The facility, operating only since October 1969, is experiencing some of the problems and difficulties common to developing programs. It has been necessary to admit new students and attempt to plan their programs while at the same time employing and training new staff members. There have been delays in initiating some departmental activities due to difficulties in recruiting professional staff.

It seemed to the visiting team that the program development was somewhat spotty, with some areas of excellence and some which needed improvement. For example, there were excellent programs for the students of the Therapy Building, offering a great variety of therapeutic and training experiences. High levels of activity for the students were evident, and a great deal of individual planning was done for them. In contrast, much inactivity and lack of structure was observed in the Community Living Program. At that time, only two cottages were occupied and the students had been there only a few months. Less than twenty students were in school programs. Students over fourteen had very few activities. According to GRC staff, this condition has now been largely corrected, and much more time is programmed for this group.

One fact which seemed to contribute to the somewhat disorganized Community Living Program was the extremely heterogeneous grouping employed which placed all ages, levels of function and behavior types in one living unit. The theory on which the system was based held that such groups are more like family units, and that the interaction between the higher and lower functioning individuals will be mutually beneficial. There seemed to be several disadvantages to this practice.

Difficulties of programming - Grouping for programming was made very difficult by the wide variations in ability. An extremely low resident to staff ratio must be maintained and much training done on a one-to-one basis. Such large staff requirements, to be justifiable, should result in measurable improvement in the students functioning, and in the return of appreciable numbers of them to the community.

Constraints placed on higher functioning students - In the team's view, children should live in separate living units from adults. Building use and safety measures must be based on the abilities of the lowest functioning students. Outer doors must be locked, and a higher level of supervision maintained than is required for the higher functioning older students. Such individuals commonly live in completely open settings in other facilities. When the older and more able share living quarters with low-functioning younger students, they are constrained in their activities and in the enjoyment of their personal possessions. After all, older family members do not normally share rooms with their very young relations. If the more able adults are being trained for eventual return to the community, they will need experience in an adult life style and increasing independence.

The direct care staff in the Community Living Program includes many people with limited experience in working with retarded persons. It will take time to develop a cadre of experienced personnel. Generally, the program assistants seem well-motivated and interested in the students. There is a high level of interaction between them and the students, and one sees little of the detached supervision and "eye-balling" often observed in institutions. Program variety should be increased by the large number of program specialists on the staff. The advocacy system employed using student chairmen seems to be advantageous to the residents, and should prevent quiet non-demanding students from being neglected.

The Center enjoys modern, well-constructed, well-equipped and comfortable buildings with many features not found in the older hospitals. The surrounding grounds are spacious and inviting, and can be used extensively in outdoor programming. At present, there is very limited on-campus space for some planned education and recreation programs, since it was hoped these services could be furnished by the community. This had not materialized at the time of the visit. The support services such as housekeeping, maintenance and food service seem to have been carefully planned. Considerable difficulty has been experienced with the laundry. Lost and damaged clothing has been a source of major complaint by parents.

The use of carpeting throughout is a mixed blessing. While carpets have many safety and noise reduction features, maintenance is a problem where food spills and toilet accidents are common. Removing soil and odors is a constant problem, and carpets must be cultured on a regular basis for contaminating bacteria. Frequent necessary shampooing of carpets causes sections of the buildings to be off-limits to students, with accompanying scheduling and management difficulties. The growing prevalence of the use of carpets throughout such facilities should receive more study.

As Georgia Retardation Center's program develops, both for outpatients and residents, it should become an excellent resource for the state.

GRACEWOOD STATE SCHOOL AND HOSPITAL

Gracewood State School and Hospital, established in 1921, was for many years Georgia's only institution specifically designed for the mentally retarded and is located near Augusta, Georgia. It occupies a spacious campus of two hundred eighty acres, and has additional acreage devoted to farming. There are twenty-seven cottages, or living units, an infirmary, a hospital, evaluation and rehabilitation center, a school building, administration building, laundry, and other buildings providing staff-housing and support services.

Of all the institutions visited, Gracewood probably has the most fully realized and fully implemented programs. This is predictable since it is the oldest specialized mental retardation facility in the state. The population has been reduced from a high of 1,902 in 1967 to 1,778 in 1970. The per diem costs have doubled in the five years since 1965 to the level of $14.39 in FY 1970. This increased expenditure has resulted in many improvements in Gracewood services, such as lower staff-resident ratios, additional programming for the residents, and expanded outpatient services. However, the visitor to Gracewood can easily observe many instances of overcrowding, poor physical facilities, and lack of programmed activities for some residents. It has been estimated by the staff that a completely adequate comprehensive program would require per diem expenditures of approximately $25.00.

Admissions and Outpatient Services

During Fiscal Year 1970 Gracewood admitted sixty-two patients as regular admissions from the waiting list, and sixty-nine as temporary, with seventeen changed to regular. Sixteen residents were transferred in from other institutions. Of the temporary admissions, thirty-five were for crisis care and twenty-four for respite care.

Psychological evaluations are done of all residents prior to their admission. Near the time of admission, the applicant's history is reviewed with the staff of the accepting area, and program plans are made. At admission, the evaluation is updated with additional history and a complete physical examination. This information is made available to ward personnel. Two weeks later, a re-evaluation of the program is made if indicated; annual re-evaluations are scheduled.

Gracewood gives extensive outpatient services, primarily through the Evaluation and Rehabilitation Center. At the time of the visit, the Evaluation and Rehabilitation staff was performing waiting list evaluations for a large service area, including metropolitan Atlanta. In FY 1970, three hundred eighty-five one-day evaluations and re-evaluations were performed by the staff. Ninety-eight families used the overnight accomodations offered by the center. Eleven families received a one-week extended evaluation and training session. This particular program seeks to train parents to manage their children more effectively in the home, thus post-

poning institutional placement. This was funded for expansion in FY 1971. In addition, the Center staff tries to help parents obtain appropriate services in their own communities. The Evaluation and Rehabilitation staff has also been active in parent counseling in the Augusta area, and in arranging visitations by local Public Health Nurses to families in other communities.

The Evaluation and Rehabilitation Center maintains a laboratory where necessary procedures such as blood counts, urinalysis and PKU testing are done routinely on all patients. When indicated, chromosome counts and other more involved laboratory procedures are performed.

The Gracewood staff is active in a public education program through visits to the facility from groups and individuals, speaking engagements by staff members, by correspondence and news stories. The staff conducts an annual one-week orientation at the facility for public health nurses. One hundred sixty-two professional visitors used the overnight facilities during the year. An "open-door" policy is maintained for visits by interested citizens, and six hundred twenty-one persons availed themselves of this opportunity during the year.

Personnel

Gracewood employed 1 259 staff members during FY 1970; sixty percent were women and fifty percent were over forty years of age. Staff member qualifications are said to meet all the requirements of the Division of Mental Health and the State Merit System. Applicants are screened by the Personnel Office; employment history, qualifications and references are checked. All staff members are given one-week of orientation training. A five year in-service training grant has been used by Nursing Education in training ward personnel, using the Attendant Training Program developed by the Southern Regional Education Board. There is approximately twenty percent turnover in attendant personnel. This is an improvement over previous years, said to be due to better working conditions, salaries and hours. There were four hundred one working residents in the cottage training program, the majority functioning in the moderate and severe ranges. In addition, three hundred sixty-seven residents worked in the facility under the VR training program.

Medical and Dental Services

At the time of the site visit, medical care to residents at Gracewood was provided by a staff of nine physicians, eight of whom were board eligible or certified in pediatrics. Consultation in specialties was available through the Medical College of Georgia. Through arrangements made with the Medical College, eight externs (fourth year students) were assigned part-time to Gracewood, and were available for twenty-four hour coverage. Residents had annual physical examinations, and daily general clinics were held. Specialty clinics were provided on a weekly basis.

The drug program was administered by a pharmacist and two technicians. A substantial portion of the drug cost was paid for by Medicaid. Acutely ill patients were served in the D-wing of the Gracewood Hospital or could be admitted to Talmadge Memorial or University Hospital if necessary.

Routine dental care was provided by three dentists and two dental hygienists, with annual dental examinations. Some dental prophylaxis was done in the treatment rooms of the cottages; this has proved to be more effective with profoundly retarded patients. Dental surgery was being done outside the institution.

The nursing department employed thirty-one RNs, thirty-three LPNs, and two hundred twenty-five other employees, mostly attendants. In addition to giving routine health care through daily clinics, immunization programs, etc., the nursing department administered the resident care program for approximately four hundred fifty residents with medical problems. Nurses were also assigned to the various units in Cottage Life. The nursing education program conducted orientation training for both employees and volunteers. Nurse instructors were assigned to six resident care units, where they conducted pre-service and staff development programs for personnel.

The staffs of the medical, dental and nursing services expressed need for additional attendants, both in the infirmary and Cottage Life program as well as an additional dentist and hygienist to provide more preventive care.

Treatment Services

Gracewood has no formal program of occupational therapy and employs no registered occupational therapist. However, an arts and crafts program was being provided by two teachers to about eighty residents at the time of the visit.

The physical therapy program at Gracewood was said to be understaffed. One registered physical therapist, an assistant and four technicians staffed the program. Patients must be referred by an orthopedist for services. The physical therapist worked in training sessions with the nurses and attendants. However, this had not been as effective as could be wished, due to understaffing in the direct care personnel. The staff estimated that two more registered physical therapists and five technicians were needed to give a full range of service to all who were eligible.

Recreation services were provided by six recreation therapists and eighteen leaders. Programs seemed to be quite well diversified over all units of the facility. Regular activities were programmed daily in all cottages and seemed to be available on some level to a large percentage of the population. Movies, dances, and parties were scheduled for night and weekend activities. Special events have included Fourth of July fireworks displays, overnight camping, Christmas parades, Special Olympics, etc.

An active volunteer program provided parties and special events by outside groups. A large number of community volunteers performed services outside the campus, such as sewing. For those residents who have lost contact with their families, there was a volunteer "adopt-a-resident" program.

Education and Training Services

Education services at Gracewood were being funded by the hospital itself rather than the State Department of Education. The program was housed in a school building constructed in 1955, which has a large gymnasium and an outdoor swimming pool. TMR classes were housed on the upper floor of an adjacent building. The print shop and TV studio, administered by the Training and Recreation Department, occupied a nearby building.

Statistics supplied the visiting team indicated that all residents eligible for school services were being served. In addition, many residents above the age limit were attending classes in homemaking arts and crafts and woodworking. Approximately four hundred residents were served in some way by the program. The school staff consisted of an instructional supervisor, fifteen teachers and three vocational education instructors. There were both morning and afternoon sessions, allowing each teacher to serve two groups. Each student attended classes for fifteen hours per week. Seventy-six students were enrolled in the EMR program, and one hundred twenty-four in the TMR program. The Speech and Hearing Department was attached to the Training Department and offered diagnostic evaluations to residents as well as outpatients. Special programs had been initiated for the deaf and hard-of-hearing.

The vocational training program provided instruction in driver education, activities of daily living, barber and beautician training, as well as on-the-job training. The team observed in a well-equipped driver education classroom and saw a completely equipped beauty shop.

The Developmental Research and Training Department provided instruction in the residential units for patients who were unable for some reason to attend the school program. The department employed a director, eleven teachers, eight part-time work therapy leaders, and a part-time psycholoical technician. Four cottages had programs of language development, and three units had cottage activity programs. An instructional program had been organized for forty non-ambulatory residents in the infirmary and hospital C-wing. The team observed a training session for approximately thirty blind students conducted in a small cottage assigned to the Developmental Research and Training Department. Teachers were working with the children with music activities, and various manipulative materials. There were then one hundred fifty-seven patients with visual impairments. The team also visited the site of a new work therapy program initiated for older severely retarded residents. This was located in a remodeled building which was being prepared for simple craft work and assembly jobs. College students were being employed part-time as supervisors.

The objective of the Vocational Rehabilitation Program was to "bridge the gap between the facility and the community." The three phases of the program stressed social and personal adjustment, work skills, and community placement. Two VR counselors and two instructors served the resident patients; one VR counselor and two instructors served outpatients. A two-week work evaluation was offered to Gracewood residents, as well as to clients referred from the state at large. Several small residences for boys and girls afforded training in independent living, so that transition to the community might be facilitated.

An estimate was made by a staff member that possible three hundred to four hundred older residents could work and live in the community. Staff members said that about sixty-five percent of the mildly retarded either had no homes or had undesirable homes, making return to the community difficult. A great need for hostels or longer-term community group homes was expressed. A second need pointed out was for a campus workshop to provide employment for moderately and severely retarded adults. This would provide a source of wages and meaningful activity to those adults who cannot function in an institution job. These clients might possibly progress to an institution or eventually a community job. The work therapy program recently initiated should partially meet this need.

Psychological Services

Psychological services were provided by a staff of two Masters level psychologists and three Baccalaureate level technicians. Psychologists were assigned to the residential care units, and two to the Evaluation and Rehabilitation Center.

Psychological evaluations of all students were made before admission and at scheduled times thereafter. The department was active in a number of living units in both individual and cottage-wide behavior modification programs, as well as in a developmental training program in the infirmary. A special group training program in various self-care skills was carried out in Cottage 18. In addition, staff members participated in the inter-disciplinary program in the Intensive Training Unit.

Resident counseling was limited due to size of the staff, although this was felt to be a need. More extensive counseling services was given to parents who visit the evaluation center; behavior management and teaching of basic skills were areas in which parent training is done.

Social Work Services

The Social Services staff consisted of two members of ACSW, two MSWs and eleven with Baccalaureate degrees. This included staff assigned to the Evaluation and Rehabilitation Center. The average caseload in resident services was approximately two hundred fifty. Comprehensive pre-admission services to families were provided, consisting of individual parent counseling, parent groups and referrals. Social workers participated in program

planning with the cottage personnel, and also gave individual and group counseling to residents. Through the Evaluation and Rehabilitation Center outpatient services were given to parents on the waiting list. An effort was made to help parents find needed services in local community programs. Liaison between parents and the institution was maintained through frequent correspondence, encouragement of home visits, and a newsletter.

Resident Care

Nursing Services Units

Nursing Services administers the resident care program for non-ambulatory residents and those with medical problems. These patients are housed in the infirmary, with three hundred beds, and in the C-wing of the hospital which serves thirty wheelchair patients. The population of the infirmary has recently been regrouped to specialize programs for residents of different functional levels, resulting in the transfer of the semi-ambulatory to the C-wing program. At the time of the visit, renovation of this wing was underway. Semiprivate rooms were being refurnished in a more homelike manner for these patients. There was storage space for personal clothing and possessions, a place to watch TV or play records.

The infirmary is housed in a large modern brick building, one of the newer constructions on the campus. Sleeping areas contained crib style hospital beds grouped in thirty-bed wards. In the large activity patios there were areas of brightly colored pattern for visual stimulation of the patients. Toys and activity materials were observed. There were two intensive care wards, serving fifty-seven, for those with more severe medical problems. A well-equipped physical therapy room was observed.

Nursing Services also administered the program in Unit 19 which served one hundred young ambulatory residents, most functioning in the severe and profound levels. The program was essentially one of early intervention and attempted to train these youngsters in self-care skills and social adjustment before poor lifelong behavior patterns could develop. The building contained a classroom where a program for residents was conducted by the Developmental Training staff.

Cottage Life Units

The Cottage Life Department administered resident care services for approximately 1,200 patients. The patients were served in four units, each containing five or six cottages. Cottage Life employed four hundred thirty-two persons. Staff-resident ratios supplied by the staff indicate that in many areas AAMD standards were met, but there seemed to be a need for additional attendants to provide more training activities and interaction with residents.

The general impression the visitor got from visiting the cottages was of overcrowded day rooms, dormitories with many beds lined up in rows, group bathrooms with little privacy. In 1970, Gracewood had two hundred ninety-two more residents than its stated capacity of 1,486. The population has been reduced from a high of 1,902 in 1967 and many improvements have been made in the program. However, there are still many unmet needs both in physical facilities and staff. Neither the arrangement of much of the living space nor the staffing pattern permits "normal" life styles. Many doors are locked, isolation rooms and restraints are used. An exception to this pattern is seen in the Activities of Daily Living Cottages, serving Vocational Rehabilitation clients.

The team visited a cottage which was undergoing renovation at the time. The sleeping areas had been partitioned to serve seven residents, with specially designed beds to fold up against the wall, and a folding table and seats. This left an area free for activities. It was hoped in this way to use the space more efficiently in programming activities for small groups. An attendant was supervising table activities. According to information, this building being renovated was only twelve years old, but reflected in its original design an out-moded concept of mass care. The team observed here locked isolation rooms where some residents were lying on a bare floor.

In another cottage dayroom the team saw a group of teenage boys watching TV after returning from a work detail. The attendant expressed concern that these boys, most of them mildly retarded, did not have enough time programmed in school and vocational training due to their work schedule. This cottage also provided only congregate living space. Dormitory rooms and group bathrooms were observed here.

The team ate lunch in Cottage 18 which housed five units of female residents of all levels and ages. Lunch was served in a large cafeteria with tables serving six to eight persons. The food was attractively served, plentiful and adequate. Cottage 18 contained some semiprivate rooms for older residents, but most of the sleeping areas were large dormitories. Efforts had been made to make these areas as attractive as possible with colorful spreads, stuffed animals and wall decorations.

The most open setting visited was Cottage 1 where the team ate lunch on the second day. Although this is one of the oldest buildings on the campus, it had a more homelike atmosphere than others visited. Residents were mildly retarded teenagers, many of them working residents. No locked doors were observed, and residents seemed to have considerable freedom. Sleeping areas upstairs were dormitory style, but had space for personal clothing and possessions. A TV lounge, and a washer and dryer, were available for use of the residents. The Cottage Supervisor seemed firm but kind, and carried out her duties much as a housemother in a girls' boarding school might do.

The central food preparation area at Gracewood was somewhat below the standards set by GRC and Central State which have newer and more modern food service buildings and equipment. The department was reported to be

short by forty-seven positions, although it was not clear what staff standards were used for comparison. Turnover in this department was said to be low, and recruiting personnel no problem. Meals eaten by the visiting team were generally good, well prepared and attractively served. All special diets were prepared in the hospital kitchen. The food was placed in containers labeled with the patients name and delivered to the cottage.

Resident's clothing varied a great deal, according to their level of function. Higher level residents were fairly neatly dressed, although clothing was wrinkled, and buttons and belts missing. Some lower functioning residents wore hospital gowns, and were without socks or shoes. Staff members expressed a preference for "common" clothing for the profoundly retarded, citing the difficulties involved with frequent changes, and the problems of keeping shoes on. The more capable residents may select clothing from a central clothing store. Team members were told that often clothing supplied by parents will not withstand the rigors of the institution laundry, and in many cases, is unsuitable.

The laundry was done in a central commercial type facility. Some personal clothing was washed in the various buildings. Diapers were washed separately from other clothing. Laundry personnel verified that profound and severe cottage clothing is not marked individually but shared. No noticeable "laundry room problems" were noted by the observer.

The team observed a good deal of inactivity among Gracewood residents, in spite of many programmed activities. Besides training and education programs, there were a number of recreation activities scheduled. A check through a week's schedule showed approximately seven hours of recreation planned for Cottage 101, housing severely retarded residents. However, not all residents participate in these activities, perhaps accounting for those often seen sitting or pacing in day rooms. Staff members completing the questionnaire estimated that from forty-eight percent to sixty percent of resident's daily time was programmed for activity.

In regard to "normalizing" life styles, the higher functioning residents seemed to have a good bit of freedom, could earn money and make purchases, receive mail and telephone calls. However, there was little privacy or places to keep personal possessions due to space limitations. Limited staff also made the use of isolation rooms, various restraints, and behavior control drugs necessary.

Religious services were provided by the Chaplaincy staff, and part-time ministers from the community. Two weekly services on Sunday and Thursday, as well as church school classes for all levels were offered. There was a chapel choir and a training choir. The choir sang from time to time in various community churches. Some residents attended church services in the community.

Comments

Of the multi-purpose institutions visited, Gracewood seemed to provide more widely available services to more residents, with longer periods of activity, and a more fully developed program. The hospital is fortunate in having many experienced staff members, both professional and non-professional.

In general, Gracewood's physical plant seemed adequate. The buildings and grounds were well maintained, clean and attractive. Even though most of the cottage living areas provide only for congregate living, the surroundings are cheerful and pleasant. The hospital and infirmary seemed to be well equipped.

The Education and Training Department has a good program, and meets the needs generally, since all eligible school students are said to be served. In addition, the school furnishes some activities for the older, non-eligible residents. The recreation staff seems to be very active, and to carry on a wide variety of activities.

Most impressive are the very real efforts made to extend training programs to those who are not school eligible on account of medical problems, multi-handicapping conditions, or low functioning levels. These groups are often neglected in training activities in institutions. However, the Developmental Research and Training Department has instituted a number of innovative programs using staff members without extensive special training. The residents are evaluated, placed in small groups and given a well structured program of activities. Many residents have shown improvement in learning and behavior. Residents who formerly had presented discipline problems have been able to participate in small groups which had interesting activities.

There are still many needs, however, in the Gracewood program. Building design for the most part does not permit small, homelike living units. Some cottages appear overcrowded. Residents have little privacy, and limited storage areas for personal clothing and possessions. Maintaining attractive and suitable wearing apparel is a problem, to judge by many residents' appearance. In the cottages serving the severely and profoundly retarded, one still sees residents in hospital gowns, shoeless, sometimes in "isolation" rooms. In spite of the many areas of programming, the staffing level is not sufficiently high to keep all residents constructively occupied most of the time.

Gracewood has many working residents who need intensive training efforts afforded them in order to return them to the community. This will require additional programming within the institution, as well as provision of sheltered living situations for them in the community. A number of Gracewood residents work in Augusta, but must live in the institution because of lack of boarding homes. A well planned, well funded and intensive program to release these residents should be instituted as soon as possible.

Gracewood has made a great deal of progress in the last decade in improving services, both to the residents and to the community.

Recommendations for Action

RECOMMENDATIONS FOR ACTION

I. To Provide Comprehensive Mental Retardation Programs in Georgia -

IT IS RECOMMENDED THAT:*

*Provision of services for the mentally retarded listed below shall be made mandatory for local health departments. These services are: day training for children excluded from public school classes and adults of post school age, work activity centers for those adults not eligible for rehabilitation services, community residential placements, diagnosis and evaluation, social services. These services may be provided either directly, or by purchase of service or contractual arrangement with private nonprofit or proprietary groups in the community. Local health departments, if necessary, can combine for certain services. Full implementation of these services shall be accomplished over a six year period, with the first year being devoted to planning, establishing guide lines and development of pilot programs in the above areas.

In "A Comprehensive Mental Retardation Plan for Georgia" published by the Georgia Department of Public Health, Division of Mental Health, in 1968, all the services listed in this recommendation, with the exception of community residential placements, were designated as the responsibility of the Health Department. Residential services in institutions have been a Health Department responsibility, and decentralizing these services throughout the state would simply change the locations of services. It seems clear that all services recommended are now being provided by the Health Department through its different administrative units, although on a scattered basis. A brief review of Health Department services will substantiate this.

On June 1, 1971, there were 1,566 retarded persons being served in mental retardation training centers (both day training and work activity) throughout the state. Seven of these centers were operated by local health departments; thirty-three private centers received Purchase of Service funds from the Health Department. Diagnosis and Evaluation Services were provided by three Health Department clinics, as well as three institutions. In addition, certain community Mental Health Programs were providing limited diagnosis and evaluation services. Local public health nurses gave limited counseling and referral services. There were no health department operated community based group homes.

Day Training and Work Activity Services were largely concentrated in metropolitan areas and larger towns. In some of the more rural health districts, only five percent to seven percent of the need for these services were met. In no area was more than twenty percent of the need met.

In order to meet the needs of all the retarded and to distribute these programs where they are most needed, the provision of these services should be made mandatory. The State Department of Public Health must provide stimulation, guidance and increased financial participation in order that services will be available at the local level. The present system which depends on local initiative has produced services primarily in urban areas where there are strong parent groups.

*The State Department of Public Health shall employ a Mental Retardation Division Chief under the Director of the Division of Mental Health. The duties of the Chief will include planning, stimulation of programs and coordination of services. The Chief will be the primary representative of mental retardation programs in dealing with local, state and federal agencies. Since mental retardation is essentially a learning rather than a medical disability, this position should be filled from disciplines other than medicine, such as social work, education, child development or psychology.

At the present time, there is no one person at the State Department of Public Health Division level representing the interests of the mentally retarded in all program areas (community services and hospital services). The Mental Retardation Division Chief should coordinate health department mental retardation programs with those of the State Department of Education, the State Department of Family and Children Services, and with federal agencies. This is of particular importance in federal funding programs. The Mental Retardation Chief should have special expertise in the problems and needs of the mentally retarded. The needs of the mentally retarded are currently represented by persons whose primary training and interest is in the field of mental illness.

*The State Department of Public Health shall make necessary organizational changes and budget additional staff positions in the Community Services Branch for Mental Retardation in order to plan, stimulate, supervise and fund the mandated services listed above. The State Department of Public Health will work in partnership with the local health departments in developing quality services.

*A Mental Retardation Services Chief shall be employed by each Health District and will be responsible to the Mental Health Chief. He will be responsible for administration, planning and program development for the mandatory services described. His office will serve as a "fixed point of referral" for all retarded persons in the district. During FY 73 the chief shall develop a plan specifying the means by which the mandated programs will be provided. Such plans should describe the nature of the working relationship between the local health unit and the regional hospital in order to maximize the delivery of service to that region. All plans shall be coordinated with the overall state plans and state needs of the mentally retarded.

The Health District Mental Retardation Chief will administer on a local level all the mandated services, and maintain an office which will be the "fixed point of referral" described in the 1962 Report of the President's Panel on Mental Retardation. Such a "fixed point of referral" is designated in the State Plan as a function of the local health department. This service, together with the appropriate social services, should be provided on a health district basis.

*The State Department of Public Health shall be empowered to set and administer appropriate statewide standards for all mandated programs supervised or funded in any way by the State Department of Public Health.

*The State Department of Public Health shall participate in the funding of community programs by a formula to be developed by legislative and/or administrative action. The formula for state participation should take into account the availability of federal funding both to local districts and state agencies.

In view of the rapidly diminishing sources of local tax income, the State Department of Public Health must greatly increase its participation in funding the mandated programs if such services are to be available to all. The present system of grant-in-aid funding has resulted in program development in only the larger and more wealthy counties. In some areas, the state should furnish one hundred percent of the program costs not provided by federal funds.

II. To Provide Appropriate Specialized Residential Programs.

In order to meet the individual needs of retarded persons needing placement outside their own homes, the following types of residential placements, described more fully in the section on the model service system, should be provided.

*The State Department of Public Health shall develop a program of foster home placement for retarded persons unable to live in their own homes. This program should serve retardates on the waiting list as well as those already placed in institutions. (Residential Service Type 1)

*Community based small group homes shall be developed under the supervision of local health districts to serve these groups of retarded persons:

--Adults requiring supervision who do not have a suitable home environment. (Residential Service Type 4)

--Children who do not have a suitable home environment. (Residential Service Type 2)

*Additional community based small group homes shall be developed under the supervision of the Division of Vocational Rehabilitation to provide a transitional living setting for young adults preparing for independent living in the community. (Residential Service Type 3)

*A fixed percentage of beds shall be reserved in the existing institutions and in the recommended community group homes to provide respite and short-term care. (Residential Service Types 7 and 8)

*Admissions to all existing facilities shall be limited to retardates whose special needs cannot be met in the community. Admissions would include these categories:

--Persons of all ages with severe physical handicaps who require skilled nursing care or special medical procedures. (Residential Service Type 5)

--Persons with severe behavior problems in need of intensive training. This would include defective delinquents requiring a highly structured or correctional setting. (Residential Service Type 6)

A significant number of mildly and moderately retarded individuals are presently residing in our medical model institutions who could function either independently or semi-independently in the community if proper supervised housing were available. Surveys done at Gracewood indicate that thirty-five to forty-five percent of the present population are inappropriately placed. Staff estimates at other institutions indicated that thirty-five percent could be placed in community settings. The results of numerous studies show predominantly that institution life has a negative effect on children. In addition, it is economically unfeasible. Cost comparisons are shown in Appendix H.

Hospital services should be reserved for those with severe medical or behavior problems who cannot be served in their home community. An estimated twenty-five percent of those now in Georgia's institutions have unusual medical needs and are probably appropriately placed. Other retarded persons needing residential placement would be better served in small group boarding homes, close to their family and friends. They should receive day training, work training, special education, recreation, and religious nurture from the resources of their own community.

III. To Improve Existing Residential Facilities -

The specific recommendations made below provide for upgrading the residential services of existing institutions, including additional personnel, and renovation of physical plant.

*Beginning immediately all existing residential facilities shall assume regional functions. This would include:

--The establishment of defined mental retardation services regions for each facility. Positive efforts should be made to locate retarded persons near their families by:

a. Limiting admissions to applicants from a given service region.
b. Transferring residents from their present institutional placement into a regional facility serving their home community.

--The provision of the following outpatient services to the service region: diagnosis and evaluation, social services including counseling and referral, assistance to local health districts in the development of community programs, special medical, dental, orthopedic services, genetic counseling. These services should be closely coordinated with the district mental retardation chief in order to avoid duplication of programs.

*The population of Gracewood State School and Hospital and the mentally retarded residents of Central State Hospital (including both Unit IX and the geographic units) shall be reduced to 1,000 patients each within a six year period. This can be accomplished by:

--Increasing the number of residents returned to the community.

a. Gracewood

..The placement in boarding homes or hostels in the community of suitable residents from among the borderline, mild and moderate retardates.
..The removal of suitable older patients to nursing homes or homes for the aged in the community. Those residents with living relatives should be placed as close as possible to their home communities.
..The placement in foster homes in the community of suitable residents.

b. Central State Hospital

..The placement in boarding homes or hostels in the community suitable residents from among the borderline, mild and moderate retardates.

..The removal of suitable older patients at Central State to nursing homes or homes for the aged in the community.
..The placement in foster homes in the community of suitable residents.

--Limitation of admissions to retardates with special problems whose needs cannot be met in the community.

--The development of alternative community programs and small residential facilities throughout the state, such as children's and adult's boarding homes.

*The second five hundred bed phase of the Georgia Retardation Center shall not be constructed. Instead, funding priority should be given to developing community based small group homes.

Over half of the older multi-purpose institutions in the United States house more than one thousand residents. However, the trend toward the smaller institution housing fewer residents has been developing for some time. Since 1960, three-fourths of the new institutions built have been planned for five hundred or less. Many mental retardation professionals agree that the larger the institution, the more impersonal its services become. In addition, there is little gained in economy or operating efficiency. There is general agreement among superintendents that increasing capacity above six to eight hundred does not reduce per capita cost.

The report of the President's Panel on Mental Retardation states:

--"Institutions for the retarded should not exceed one thousand beds and those whose population presently exceeds this number should take steps to provide small living units within the facility to provide individual care.

--"Residential facilities now being planned and those to be built in the future should not exceed five hundred beds in general, and for certain specific purposes, any number under that might well be regarded as advantageous."

In recommendation Number 70 of A Comprehensive Mental Retardation Plan for Georgia published by the Georgia Department of Public Health, it is stated: "No residential unit for the mentally retarded should exceed a five hundred bed capacity." While this appears to refer specifically to the new regional hospitals, the same rationale would seem to apply to other institutions.

In view of these facts, we believe that the size of Gracewood and the mental retardation unit of Central State should be reduced to one thousand each. With the reduction of resident population, the existing staff and physical plant would become increasingly more adequate and less crowded.

The second phase of the Georgia Retardation Center would require large capital expenditures and $5,000,000 each year to operate at the present per diem costs. The operating costs alone would serve over one thousand two hundred retarded persons in community group homes, without any construction costs. For this reason, we recommend that the second phase of the Georgia Retardation Center not be constructed.

*The living units at Gracewood and Central State Hospital shall be remodeled to promote more normal physical surroundings. This may necessitate retraining of long term institutionalized residents. This may be done by:

--Remodeling of congregate wards into small living units, with sleeping areas with two, four and six bed units.

--Remodeling of dayroom areas into smaller units, with areas zoned for different kinds of activities such as music, quiet games, TV.

--Making all areas more homelike by furnishing them with regular furniture, curtains, pictures, plants, toys, games and other activity materials.

--Providing each resident with a separate storage space for his clothing, grooming materials, personal possessions, family pictures.

--Providing easily accessible safe outdoor space for play, exercises, games. This may require fencing of some areas.

In 1966, Jungjohann and Kaufman reported that when severely retarded children were provided with a family-like living experience in an institution they exhibited more social behaviors and less stereotyped behavior than children living in a typical institution setting. Other studies have shown that the negative effects of traditional mental retardation institutions may be modified by reducing the size of living units and providing a more homelike atmosphere.

*Every effort shall be made to promote the human rights, dignity and self-concept of residents of all functioning levels at all our state institutions. This may be done by:

--Insuring each person's right to his own personal possessions. Residents of all levels should wear personal clothing, and shoes; staff time necessary to accomplish this should be provided. Only in this way will the resident be perceived as a human being and an individual either by himself or by the staff.

--Insuring each person's freedom of movement to the utmost extent possible. Doors should not be locked unless it has been found impossible to train residents to adjust to an open setting. Residents

should be trained to move about the buildings and grounds with supervision. Residents should be free to write and receive mail, make and receive telephone calls if they are able.

--Insuring that each resident develops as much independence and pride in appearance as possible by intensive training in toileting, dressing, feeding, grooming. Residents of every level should be assisted in maintaining a neat and well-groomed appearance through proper hair cutting, hair dressing, shaving. Clothing should be maintained in a clean, repaired and reasonably attractive condition.

--Insuring each resident freedom to communicate and associate with persons of the opposite sex under proper supervision.

*The State Department of Public Health shall conduct a manpower survey to assess its short and long term personnel requirements for residential care. A study should be made of the proper roles and functions of professional and non-professional staff. Based upon present observations, it will be necessary to increase the quality and quantity of both professional and direct care personnel. High priority should be given to the direct care staff needs of Central State Hospital.

*The State Merit System shall rewrite the job description of the entry level direct care position to redefine duties in order to place more emphasis on training, behavior management, and resident interaction. A career ladder should be planned to offer opportunities for job mobility based on work skills and additional training rather than solely on longevity.

*The State Merit System shall create and provide a job description for a middle level position in direct care in residential facilities. Such a position would require more than high school but less than four year college work. Preparation for this position will include a course of study such as that currently offered in the Mental Health Assistant program at Georgia State University.

*New and innovative training programs for entry level direct care and middle level personnel in residential institutions shall be planned by the State Department of Public Health. Such programs should provide for initial training in work skills and ongoing education in preparation for higher level positions. These programs should emphasize the training and rehabilitation of residents, rather than traditional nursing care. Training can be provided in a number of alternative ways, such as:

--A training program at Georgia Retardation Center for non-professional personnel, combining classroom and practical experience.

--A stipend program for non-professionals to attend classes at community and junior colleges, and technical schools offering special courses of study leading to certification.

--Correspondence courses from universities.

--Special certificate training programs conducted by the employing institution.

*A sufficient number of direct care personnel shall be employed principally in the units for severely and profoundly retarded at Gracewood and Central State to increase the level of training and provide a greater amount of organized activity for the residents. Any additional staff employed should be used in initiating new programs and activities, rather than simply sharing traditional direct care staff duties. All new programs should be resident-directed rather than ward-directed. Through staff development training or administrative directive, existing staff should be made more responsive to the training and activity needs of the residents. Direct care staff should understand, support and participate in resident training activities initiated by the professional staff. In addition, present direct care staff could function more effectively by dividing large resident groups into smaller ones, and assigning small groups to specific individuals.

The most outstanding program deficiencies in residential facilities were observed in wards for the severely and profoundly retarded at Central State Hospital. More activity and training must be added to the existing program. It has been demonstrated by special training teams both at Gracewood and Central State that the skills of these residents can be improved with additional staff, and well planned, highly structured activities.

*Adjunctive therapy services, particularly physical therapy, shall be provided to the three wards housing non-ambulatory and physically handicapped residents of Central State Hospital and the Rosehaven Unit of Southwestern State Hospital. The necessary staff positions and equipment needs should be budgeted.

*Additional staff positions shall be budgeted at the Georgia Regional Hospital at Atlanta to furnish expanded adjunctive therapy services, particularly physical therapy. Equipment and materials necessary to implement such a program should be funded.

Children and adults with severe physical handicaps should receive adjunctive therapy services, regardless of where they are placed. Physical therapy services should be available to all who need them, not limited to patients at certain hospitals.

At the present time there are no physical therapy services at Central State Hospital and Southwestern State Hospital, and only limited services at the Georgia Regional Hospital at Atlanta.

*Social Services Departments in all residential facilities shall employ adequate staff to provide the following services:

--Outreach functions with resident's families. This should include preadmission services, contact with families during the residence period and follow-up services with the family if and when the resident returns home.

--Outreach functions with agencies and resources in the resident's home community. This should include local public health nurses, Department of Family and Children Services, and other agencies having any understanding of the retardate and his family. Information from these contacts should be made available to staff members working with the resident, in the form of a written report, preferably before the admission of the resident.

--Development and coordination of services needed to return the resident to the community. This should include program planning toward developing the retardate's skills to function in the community, maintenance of contact with agencies who might work with the resident in the community, and providing necessary supervision to the resident during the transition period and actual establishment in a community placement.

--Provision of social services to a regional service area, including evaluation recommendations, referrals, and counseling.

*The Mental Retardation Unit at Central State Hospital should be established as a separate institution, with a separate budget and administration, and under a new name. Supportive services should still be provided by Central State Hospital on a contractual basis. Nursing Services should continue to administer wards serving non-ambulatory residents and those with medical problems. Resident living services for ambulatory residents without medical problems should be reorganized under a Cottage Life Department, rather than under Nursing Services. Program goals should emphasize education, habilitation, socialization and health care. The program should reflect the fact that most mentally retarded persons primarily have learning disabilities rather than medical disabilities.

*Admission of mentally retarded patients to the geographic units of Central State Hospital shall cease immediately, with the exception of special hardship cases or extreme emergencies. All such admissions should be processed through the Central Hospital Admissions Office. All mentally retarded persons now resident in the geographic units shall be removed and placed in appropriate mental retardation programs.

Central State Hospital serves approximately eight hundred mentally retarded residents in Unit IX (the Boone and Boland Buildings). In 1970 an additional one thousand mentally retarded

residents were dispersed in the geographic units for the mentally ill. The total of 1763 mentally retarded residents represented approximately one-quarter of the total population of Central State Hospital.

The mentally retarded have special problems and needs which make them a unique group from the viewpoint of care. It would appear that on the basis of efficient management, and provision of appropriate services to meet these needs, a separate mental retardation facility should be established. This facility would serve all the retarded residents at Central State, and would require the removal of those now in geographic units into the special mental retardation program. With extensive renovation, the existing buildings of Central State could house this program. At the time of this reorganization, Medicaid units should be placed under Nursing Services, and units for those without severe medical problems organized under a non-medical model.

In Fiscal 1970, only three hundred thirty new residents were admitted to all the institutions through the Hospital Admissions Office. Yet three hundred fifty-six mentally retarded were admitted to the geographic units of Central State alone. These statistics show that placement of over three hundred mentally retarded persons in some way were effected outside regular hospital admissions procedures.

In addition, eighty percent of all retardates over twenty-one admitted in FY 70 were placed in programs for the mentally ill at Central State Hospital. Parents who had maintained their mentally retarded children to the best of their ability throughout their lifetime have been forced to accept these extremely inappropriate placements when they were no longer able to provide supervision. Such placements must be ended at the earliest possible moment.

*Georgia Retardation Center shall employ other methods of grouping rather than the present heterogeneous grouping. This recommendation is made in light of the disadvantages discussed in the site visit report. It is maintained that more normal life styles could be enjoyed by higher level students, in a more homogeneous grouping. A higher level of structuring shall be employed in program activities particularly for younger, lower functioning students in the cottages. Most mentally retarded persons benefit from well-planned, highly organized activities.

*The staff of Gracewood shall increase the school and vocational services offered working residents in order to enable them to move toward community placement. A work training program with pay shall be offered to those working in the institution. A substantial number of the working residents should be candidates for community placement.

*In order to return to the community those residents judged to have potential for independent living, the residential facilities shall initiate a full and comprehensive pre-release program within the institution. Program goals would seek to prepare the individual for community life through training in proper dress and grooming, money management, household skills, and actual visits to the community. Essential to this program is the simultaneous development of transitional and long-term community residential facilities (Residential Service Types 3 and 4) and comprehensive community vocational facilities.

*Work activity programs shall be provided for older residents of institutions who cannot function in a community job placement or perform an institution job. These services should ideally be provided in the community, with transportation of residents to the program. If no community programs are available, they should be provided within the institution. Program goals should include the provision of work, wages and job skills which might eventually enable the resident to progress to vocational rehabilitation services. Such work activity centers should be open to retardates with the same needs living in commuting areas.

*The Georgia Retardation Center shall be placed under the Hospital Services Branch, and shall provide regional services. Training and research activities should be continued with increased emphasis on training of non-professional personnel. The primary objectives of the facility should be service oriented.

*Charges for residential services for the mentally retarded shall be eliminated by legislative action. Such action would provide services to the mentally retarded consistent with those provided without charge to individuals with other handicapping conditions.

The State of Georgia, through the State Department of Education, provides state residential schools without charge to children with visual and hearing impairment. In addition, it provides a substantial portion of the cost to enroll multi-handicapped children in out-of-state residential schools. In effect, parents of blind and deaf children can receive free residential placement throughout their childrens school years.

In contrast, parents of mentally retarded children are liable for payment for residential services for the entire lifetime of their child. If residential services cannot be offered totally without charge, parent's liability should cease after the child becomes twenty-one years old.

*The Governor shall appoint a Board of Visitors, the members to visit the institutions three times each year and report their findings to the Governor and the State Department of Public Health. The Board should include legislators, mental retardation professionals, an attorney, and parents of mentally retarded. Half of the Board's number should represent parents from all socioeconomic and racial groups.

*That Georgia participate in the Interstate Compact on Mental Health.

IV. To Provide for Planning

*A planning body be established to insure continued implementation of these recommendations. Specifically, it is recommended that the legislature appoint a special advisory committee whose duty it will be to review the planning of the State Department of Public Health and make long range projections to the legislature of budgetary needs. The committee shall consist of legislators from both houses, professionals in the field of mental retardation, and parents of mentally retarded persons.

The plan of action drawn up by the State Department of Public Health shall be reviewed by the special advisory committee.

BUDGET NOTES

The amounts suggested for funding in Fiscal Year 1973 are proposed to accomplish these ends:

--Establish the office of Division Mental Retardation Chief.

--Establish offices of District Mental Retardation Chiefs in each health district.

--Expand community day training and work activity programs by approximately seventy-five percent.

--Begin a pilot program of community group homes in each health district serving primarily mildly and moderately retarded adults.

--Establish five hostels to be operated by Vocational Rehabilitation in selected urban areas.

--Reorganize Central State Mental Retardation Program as a separate unit, hire additional direct care personnel, and begin physical renovation of buildings.

--Provide physical therapy programs at Central State Hospital and Southwestern State Hospital, and expand the physical therapy program at the Georgia Regional Hospital at Atlanta.

The budget requests are made, not on the basis of total need, but to make a beginning in implementing these programs.

I.	Appropriations for State Health Department (FY 72)		
	Supplemental appropriation requested to allow immediate participation in Title IV-A funding		$ 700,000
II.	Appropriations for State Health Department (FY 73)		
	Division of Mental Health		
	Division Mental Retardation Chief	$ 25,000	
	District Mental Retardation Chiefs Offices (15)	300,000	$ 325,000
	Community Services Branch		
	Day Care Training & Diagnostic Services (FY 72 appropriation $700,000)	1,400,000	
	Group Homes		
	Operational (including rent)	300,000	
	Initial capital outlay to furnish group homes	225,000	$1,925,000
	Hospital Branch		
	Central State Hospital		
	Personnel (Reorganization under Cottage Life)	233,000	
	Director of Unit	$ 16,000	
	Secretary	5,000	
	Asst. Director (In-Service)	12,000	
	Additional Direct Care Staff	$200,000	
	Physical Renovation	1,000,000	
	Physical Therapy Program	60,000	
	Southwestern State Hospital		
	Physical Therapy Program	45,000	
	Georgia Regional Hospital at Atlanta		
	Physical Therapy Program	40,000	$1,378,000
III.	Appropriations for State Department of Education (FY 73)		
	Vocational Rehabilitation Hostels		
	Operational (including rent) and initial capital outlay for furnishings		$ 150,000
		Grand Total	$4,478,000

Appendix

APPENDIX A

DECLARATION OF GENERAL AND SPECIAL RIGHTS OF THE MENTALLY RETARDED

Whereas the universal declaration of human rights, adopted by the United Nations, proclaims that all of the human family, without distinction of any kind, have equal and inalienable rights of human dignity and freedom;

Whereas the declaration of the rights of the child, adopted by the United Nations, proclaims the rights of the physically, mentally or socially handicapped child to special treatment, education and care required by his particular condition.

Now Therefore

The International League of Societies for the Mentally Handicapped expresses the general and special rights of the mentally retarded as follows:

ARTICLE I
The mentally retarded person has the same basic rights as other citizens of the same country and same age.

ARTICLE II
The mentally retarded person has a right to proper medical care and physical restoration and to such education, training, habilitation and guidance as will enable him to develop his ability and potential to the fullest possible extent, no matter how severe his degree of disability. No mentally handicapped person should be deprived of such services by reason of the costs involved.

ARTICLE III
The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to productive work or to other meaningful occupation.

ARTICLE IV
The mentally retarded person has a right to live with his own family or with fosterparents; to participate in all aspects of community life, and to be provided with appropriate leisure time activities. If care in an institution becomes necessary it should be in surroundings and under circumstances as close to normal living as possible.

ARTICLE V
The mentally retarded person has a right to a qualified guardian when this is required to protect his personal wellbeing and interest. No person rendering direct services to the mentally retarded should also serve as his guardian.

ARTICLE VI
The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If accused, he has a right to a fair trial with full recognition being given to his degree of responsibility.

ARTICLE VII
Some mentally retarded persons may be unable, due to the severity of their handicap, to exercise for themselves all of their rights in a meaningful way. For others, modification of some or all of these rights is appropriate. The procedure used for modification or denial of rights must contain proper legal safeguards against every form of abuse, must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic reviews and to the right of appeal to higher authorities.

ABOVE ALL
THE MENTALLY RETARDED PERSON
HAS THE RIGHT TO RESPECT

October 24, 1968.

The International League of Societies for the Mentally Handicapped

APPENDIX B

REFERENCE MATERIALS

A Comprehensive Mental Retardation Plan for Georgia, Atlanta, Georgia, Department of Public Health, Division of Mental Health, 1968.

Directory of Mental Retardation Services in Georgia, Atlanta, Georgia, Georgia Council on Mental Retardation and the Georgia Department of Public Health, March 1971.

Heber, Rick, A Manual on Terminology and Classification in Mental Retardation, Columbus, Ohio, A Monograph Supplement to the American Journal of Mental Deficiency, Second Edition, 1961.

The Initiation and Development of a Comprehensive, County-Wide System of Services for the Mentally Retarded of Douglas County, Vol. I, Omaha, Nebraska, Greater Omaha Association for Retarded Children, Inc., 1968.

The Initiation and Development of a Comprehensive, County-Wide System of Services for the Mentally Retarded of Douglas County, Vol. II, Omaha, Nebraska, Greater Omaha Association for Retarded Children, Inc., 1968.

Jungjohann, Eugen and Kaufman, Melvin E., "An Evaluation of a Milieu Therapy Programme for Severely Retarded Children in an Institution," Journal of Mental Subnormality 12(23), pp. 61-65, 1966.

Kugel, R. B. and Wolfensberger, Wolf, (eds.), Changing Patterns in Residential Services for the Mentally Retarded, Washington, D.C., President's Committee on Mental Retardation, 1969.

Legislative Aspects of Mental Retardation, Stora Skondal, Stockholm, International League of Societies for the Mentally Handicapped, 1967.

Nirje, Bengt, "The Normalization Principle and Its Human Management Implications," in Changing Patterns in Residential Services for the Mentally Retarded, Washington, D.C., President's Committee on Mental Retardation, 1969, pp. 179-187.

Policy Statements on Residential Care, New York, N. Y., National Association for Retarded Children, October 1968.

A Proposed Program for National Action to Combat Mental Retardation, Washington, D.C., President's Panel on Mental Retardation, 1962.

The Report of the Nebraska Citizen's Study Committee on Mental Retardation, Vol. I, Nebraska, July 1968.

The Report of The Nebraska Citizen's Study Committee on Mental Retardation, Vol. II, Nebraska, July 1968.

Residential Services for the Mentally Retarded: An Action Policy Proposal, Washington, D.C., President's Committee on Mental Retardation, 1970.

Respite Care for the Retarded, Washington, D.C., U. S. Department of Health, Education, and Welfare, 1970.

A Review of Georgia's Mental Health Program, 1960-1971, in Report to the Governor's Commission to Improve Services for Mentally and Emotionally Handicapped Georgians, State Department of Public Health, 1971.

Roos, Philip, Current Issues in Residential Care, Arlington, Texas, National Association for Retarded Children, 1969.

Standards for State Residential Institutions for the Mentally Retarded, Columbus, Ohio, Monograph Supplement to American Journal of Mental Deficiency, Vol. 68, No. 4, January 1964.

A Survey and Study of State Institutions for the Mentally Retarded in the United States, Vol. II, New York, N. Y., National Association for Retarded Children, 1963.

APPENDIX C

RESIDENTIAL STUDY

Name of Institution _____

Dates of Visit _____

Visiting Team Members _____

Persons Interviewed _____

CHECK-LIST - For Each Facility

I. Administration

A. Admissions and Separations

1. Statistics

RESIDENT POPULATION AS OF JUNE 30, 1970 BY AGE AND MEASURED INTELLIGENCE

ADMISSIONS DURING FISCAL 1970 BY AGE AND MEASURED INTELLIGENCE

a. Number temporary admissions for crisis care_____
b. Number admissions for respite care_____
c. Number admissions for evaluation_____
d. Number admissions from emergency priority_____
e. Number separations, distributed by categories such as transfer, release to community, death, etc._____
f. Services made available to out-patients from institutional service area_____
g. Number of out-patients served_____

2. Is there a comprehensive evaluation by a professional team at time of admission?

3. Is evaluation information available to staff and is it discussed with ward personnel?

4. Are residents re-evaluated and programs reviewed at regular intervals?

5. Do release procedures include parent counseling, physical check-up, notification of appropriate community agencies?

B. Staff Development

1. Is orientation training provided all staff members?

2. Is ward personnel provided initial in-service education?

3. Is ward personnel provided continuing in-service education?

4. Is professional staff provided continuing in-service education?
5. Is disaster procedure training provided all staff members?
6. Is there a formal career ladder available to all levels of employment?

C. Research

1. Statistics - List research projects currently conducted, annual budget for project, source of funding.
2. Are adequate clerical and statistical services available to provide complete population data?
3. Is informed consent of resident, parent or guardian obtained prior to participation in research?
4. Is confidentiality of all findings assured?
5. Is the mental and physical well-being of resident protected?

D. Public Education

1. Statistics
   a. Number of visits from legislators from Atlanta area_____
   b. Number of visits from legislators from state at large____
2. Number of visits from civic, community, and professional groups__
   How are these visits encouraged?
3. Number of visits from school and college classes_____
   How are these visits encouraged?

E. Personnel Policies

1. Do all administrative and professional staff members meet the qualifications and certifications required by the Division of Mental Health?
2. Is there initial screening of all personnel?
   By whom
   Screening criteria
3. Where are personnel records kept?
4. Does the institution use residents to provide institutional services?
5. Staff distribution by age
   Staff distribution by sex
6. Are working residents protected from exploitation by administrative policy?
7. Number of working residents by degree of retardation.

F. Written Policies and Materials

1. Is there a written statement of the goals and philosophy of service of the institution?
2. Is there a table of organization delineating responsibility?
3. Is there a written plan for emergency procedures such as fire, other disaster, missing resident?
4. Is there a written manual covering the function of each primary department?

5. Are these documents available to all staff members and the information taught in orientation training?
6. Proposed budget 1970_____Adopted budget 1970_____

II. PROGRAM SERVICES

A. Medical and Dental

Number of full time staff_____
Number of part-time staff_____
Number of board diplomates_____
Number of board eligible_____
Number licensed_____
Number of foreign medical graduates_____

1. Is a qualified physician available for 24 hour coverage?
2. Is an acute medical and surgical hospital available? Where?
3. Are services of clinicians in medical specialties available? On consultant basis - On regular basis
4. Is there routine medical supervision of general health?
5. What services and programs need medical referral?
6. Does each resident have a regular physical examination?
7. Is there a pharmacy, pharmacist and drug program? Who supervises the drug program?
8. Are immunizations as recommended by the Health Department kept current?
9. Are periodic sanitary inspections made as required by state codes?
10. Are separate facilities provided for the acutely ill resident and the resident requiring continuous skilled nursing care?
11. Are there special provisions for residents who are not yet mobile?
12. Is there routine dental care and treatment on a scheduled basis?
13. Are prosthetic dental devices provided when necessary?
14. Are visual and hearing screening tests administered?
15. What is the system for keeping medical records?
16. What is the system for keeping cumulative records?

B. Nursing Services

Number R.N._____Number L.P.N._____Others_____

1. Where appropriate to the population served, are nursing supervision and nursing services provided?
2. Is there an ongoing program of nursing education?
3. Does the resident who is acutely ill receive skilled nursing care?

C. Educational and Rehabilitation Programs

1. Statistics
   a. EMR Classes (school age)
      Number of residents eligible_____
      Number served_____

Percent of eligible residents served_____
Number of hours per week in class_____
Staff
Number of certified teachers (special education)_____
Number of teaching aides_____

b. TMR Classes (school age)
Number of residents eligible_____
Number served_____
Percent of eligible residents served_____
Number of hours per week in class_____
Staff
Number of certified teachers (special education)_____
Number of teaching aides_____

c. Vocational Training
Number of residents eligible_____
Number served_____
Percent of eligible residents served_____
Number of hours per week in training_____
Number vocational teachers in program_____
What training is done toward community placement?
Number residents considered feasible for community placement__

2. Does the staff include special education teachers, speech and hearing therapists, vocational instructors or obtain these services from the community?

3. Are there special services for blind, deaf and multihandicapped?

4. Are classes and vocation training co-educational?

5. Are records of school and vocational training kept?

6. Does the educational and vocational program meet the standards of the State Department of Education?

7. Speech and hearing therapy provided
Number speech therapists____
Number children in therapy program____

D. Psychological Services

1. Statistics
Staff: Ph.D._____ Masters level_____ Baccalaureate_____
2. Does the psychologist provide evaluation of intelligence and behavior?
3. Does the psychologist participate in programming for residents?
4. Does the psychologist participate in behavior modification programming?
5. Are psychological tests repeated on planned schedule and for special cases?
6. Are test results interpreted to staff?
7. Is there resident counseling? If so, of what type?
8. What services do psychologists provide retardates and their families living in communities within the service area?

E. Social Services

1. Are pre-admission services offered?
2. Do social workers participate in program planning and placement?
3. Do social workers participate in community placement, jobs, foster homes, etc.?
4. Ratios Staff
   Number of staff_____
   Number ACSW_____MSW_____Baccalaureate_____Less_____
   Average caseload - pre-admission services_____
   Average caseload - admissions services_____
   Average caseload - resident services_____
   Average caseload - foster home placement services_____
   Average caseload - community training and employment services_
5. Maintenance of family and community contact
   Number of family visits_____
   Number of resident visits to family____
   Is there a newsletter for family and community contacts____
   Number of residents never visited_____
   Community agency contacts_____
6. Is there resident counseling? If so, of what type?
7. What services do social workers provide retardates and their families living in communities within the service area?
8. How are process recordings maintained and to whom are they available?

F. Treatment Services

1. Occupational therapy
   a. Number of registered occupational therapists employed____
      Number of others_____Number residents in occupational therapy programs_____
   b. Do occupational services include industrial therapy, music therapy, recreation therapy?
2. Physical therapy
   a. Number of registered physical therapists employed_____
      Number of others_____
   b. Do physical therapy services include ambulation and muscle conditioning?
   c. Are braces, walkers, and other physical rehabilitation equipment provided?
3. Recreation therapy
   a. Number of registered recreation therapists employed_____
      Number of others_____
   b. Are recreation services offered to all residents, based on their abilities?
   c. Are activities co-educational where possible?
   d. Are evening and weekend recreation programs offered?
   e. Are staff shifts staggered?

G. Volunteer Services

1. Number of volunteers in program_____
2. Is there a full time supervisory staff member?

III. RESIDENT CARE

A. Staff - Titles of positions, roles and functions
1. Has the director of program experience in institutional service, and broad knowledge of principles of growth and development?
2. Direct care personnel have:
   High School education
   Ability to work with handicapped persons
3. Staff ratios (Ratios of the first, second and third shifts plus the overall ratios in the following categories.)
   a. Category I - Medical and surgical units
   b. Category II - Special treatment units; infants and children up to six; and profoundly and severely handicapped.
   c. Category III - Children from about six to puberty not in I and II; moderately physically handicapped; adolescents needing considerable adult guidance and supervision.
   d. Category IV - Residents in late adolescence or adulthood who are aggressive, assaultive, or security risks; residents who manifest hyperactive, psychotic-like behavior, with impulsive, assaultive behavior.
   e. Category V - Trainable adults and adolescents in need of habit training.
   f. Category VI - Adults who are stable, able to work in living areas, or work in sheltered activities; and residents in vocational training programs being prepared for community placement.

B. Food Service

1. Do food service procedures meet state and local regulations?
2. Food is served:
   In an attractive manner
   In sufficient quantity
   Using full table service when appropriate
   In small groups
3. Does the ward personnel teach self-feeding?
4. Are special diets furnished when necessary?
5. How are special diets supervised?
6. Does an official staff member eat residents diet?

C. Clothing and Laundry

1. Does each resident have adequate, neat clothing?
2. Does each resident use his own marked clothing?
3. Does each resident have a storage area to which he has access?
4. Is there adequate storage for clean and soiled laundry?

D. Hygiene and Health Measures

1. Does ward personnel teach residents dressing, toileting, and grooming procedures?
2. Do ambulatory and non-ambulatory residents have daily planned exercise, out-of-doors when possible?

3. Do residents have appropriate clothing for all-weather outdoor activities?
4. Are incontinent residents kept clean by ward personnel?
5. Do residents bathe regularly?
6. Is residents hair neatly cut and groomed?
7. Is there program of foot care?
8. Do residents all receive adequate drinking water?
9. Are hearing aids, glasses, braces acquired and maintained?
10. Is there a sex education program?
11. What are policies concerning sterilization?
12. What are policies concerning birth control measures?
13. How are sex problems handled?

E. Normalization Procedures

1. May residents who are capable write and receive uncensored mail?
2. Do residents have access to a telephone?
3. Do residents have own spending money?
4. Do residents have place to make small purchases?
5. Do residents visit and make trips in community?
6. Do arising and bed times maintain normal rhythm of community?
7. Does each resident have place to keep and display his personal possessions such as family pictures, keepsakes, etc.?
8. Are isolation and quiet rooms used for specific purpose for limited time?
9. Are restraints used? What types?
10. Are residence units organized to maximize staff contact with residents?

F. Religious Services

1. Staff - Titles, roles and functions
2. What religious programs are offered residents on campus?
3. Do religious services offer any opportunities to bring residents in contact with the community?

G. Cottage Life Activities

1. Percentage of daily time programmed for different MR levels.
2. Does each resident, regardless of age or level of function, have a planned program of activities?
3. Is there a program for training all residents in self-care skills up to their potential?
4. Do school age residents not capable of attending special education classes have a planned training and recreation activity?

H. Cottage Living Areas

1. Statistics

Unit residences house (minimum)_____ to (maximum)_____
Number of single bed rooms_____
Number of 2 and 3 bed rooms_____
Number of 4 bed rooms_____
Number of 5 and 6 bed rooms_____
Number of dormitory beds_____

2. Are day or activity rooms attractive and pleasant with equipment for quiet activities?
3. Do bath room and toilet areas provide privacy?
4. Do playground areas show evidence of use?

IV. Physical Plant

A. Statistics
List of buildings, age, present use, approximate square footage.

B. Ratios
Toilets to residents_____
Lavatories to residents_____
Bath units to residents_____
Number square feet per bed_____
Stated resident capacity of institution___

C. Is there provision for emergency heating and lighting?

D. Do sleeping and day rooms have outside ventilation?

E. Are all fire and safety regulations complied with?

1. Safe exits from buildings
2. Handrails on stairs
3. Safety shields on moving machinery
4. Thermostatic-controlled mixing valves on bath tubs

F. Do buildings and grounds comply with local sanitation and plumbing regulations - water, garbage, plumbing?

G. Are windows and doors screened?

THE MODEL COMPREHENSIVE SERVICE SYSTEM

	DIAGNOSTIC AND EVALUATION SERVICES	FAMILY SERVICES	MENTAL AND PHYSICAL HEALTH SERVICES	EDUCATION AND TRAINING SERVICES	WORK TRAINING SERVICES
PRESCHOOL	Initial Diagnosis Medical Social Psychological Developmental Nutritional Fixed point of referral	Parent counseling and education Referral and placement Respite care Parent relief (baby sitters, homemakers)	Routine health care Specialized medical follow-up Corrective medical procedures - (visual, hearing, orthopedic, dental, and cosmetic) Genetic evaluation	Preschool Centers Day training centers Home training	-----
CHILDHOOD AND YOUTH	Scheduled re-evaluation Vocational evaluation Educational evaluation	"	Counseling Corrective procedures Routine health care Specialized medical follow-up Premarital counseling	EMR and TMR classes Day training centers Home training	Pre-vocational training Vocational counseling Vocational training
ADULT	Periodic re-evaluation	"	Routine health care Specialized medical follow-up General counseling Premarital counseling Marital counseling Health insurance Medicaid	Adult education Adult activity centers	Vocational counseling Vocational training Sheltered workshop Job placement and follow-up
AGED 65+	Periodic re-evaluation	-----	Routine health care Specialized medical follow-up Counseling, Medicare Health Insurance	-----	-----

THE MODEL COMPREHENSIVE SERVICE SYSTEM

	ECONOMIC-LEGAL SUPPORTIVE SERVICES	RECREATION SERVICES	RELIGIOUS TRAINING SERVICES	TRANSPORTATION SERVICES	RESIDENTIAL SERVICES
PRESCHOOL	Citizen advocacy Guardianship of property and person Protective services	Day camp	Church School classes	Transportation to Education and training services, Health clinics	Nursing home for medical problems Temporary respite centers Foster homes Intensive training residence for severe behavior problems
CHILDHOOD AND YOUTH	Citizen advocacy Guardianship of property and person Protective services	Boy, girl scout troops Organized playground and athletic programs Day camp Residential camp	Church School classes Church affiliation training Church services	Transportation to Education and training services, Recreational services, Health clinics	" plus Small group homes (pre-adolescents and adolescents)
ADULT	Citizen advocacy Guardianship of property and person Income maintenance OASI Aid to permanently and totally disabled	Holiday and vacation activities Organized adult physical exercise programs Leisure time activities	Church services and fellowship groups	Transportation to Activity centers, Sheltered workshops Recreational services Health clinics	Nursing home for medical problems Temporary respite centers Foster homes Intensive training residence for severe behavior problems Small group homes Hostels
AGED 65+	Citizen advocacy Guardianship of property and person Income maintenance OASI Aid to permanently and totally disabled	"	Fellowship groups and Church services	Transportation to Activity centers, Sheltered workshops, Recreation services Health clinics	"

DEVELOPMENTAL CHARACTERISTICS OF THE MENTALLY RETARDED*

LEVEL OF RETARDATION	PRESCHOOL AGE 0-5 MATURATION AND DEVELOPMENT	SCHOOL AGE 6-21 TRAINING AND EDUCATION	ADULT 21 SOCIAL AND VOCATIONAL ADEQUACY
Mild IQ 55-69	Can develop social and communication skills; minimal retardation in sensori-motor areas; rarely distinguished from normal until later age.	Can learn academic skills to approximately 6th grade level by late teens. Cannot learn general high school subjects. Needs special education particularly at secondary school age levels. ("Educable")	Capable of social and vocational adequacy with proper education and training. Frequently needs supervision and guidance under serious social or economic stress.
Moderate IQ 40-54	Can talk or learn to communicate; poor social awareness; fair motor development; may profit from self-help; can be managed with moderate supervision.	Can learn functional academic skills to approximately 4th grade level by late teens if given special education. ("Educable") ("Trainable")	Capable of self-maintenance in unskilled or semi-skilled occupations; needs supervision and guidance when under mild social or economic stress.
Severe IQ 25-39	Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.	Can talk or learn to communicate; can be trained in elemental health habits; cannot learn functional academic skills; profits from systematic habit training. ("Trainable"-IQ 35+)	Can contribute partially to self-support under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.
Profound IQ 0-24	Gross retardation; minimal capacity for functioning in sensori-motor areas; needs nursing care.	Some motor development present; cannot profit from training in self-help; needs total care.	Some motor and speech development; totally incapable of self-maintenance; needs complete care and supervision.

*Heber, 1961, A Manual on Terminology and Classification in Mental Retardation The American Association on Mental Deficiency.

CENTRAL STATE
COMPARISON OF 1970 DIRECT CARE STAFF RATIOS WITH AAMD STANDARDS

Living Unit	Category	Number Beds	Attendants Assigned to Day Shift	Total Complement Needed to meet AAMD Standards
Boone 1	V	57	3	6
Boone 2	V	53	3	6
Boone 3	II	60	5	12
Boone 4	II	58	6	11
Boone 5	II	58	5	11
Boone 6 (Medicaid)	III	96	12	13
Boone 7 (Medicaid)	III	88	8	12
Boone 8	III	38	4	6
Boone 9	V	60	3	6
Boland 1	II	60	5	12
Boland 3	III	43	3	6
Boland 4	II	43	4	8
Boland 5	V	68	3	7
Boland 6	V	60	3	6
			Total Assigned - 67	Total Needed - 122

COMPARISON OF COSTS FOR LIFETIME SERVICES

I.	Placed in Gracewood at age 6 for lifetime (till 65 @ $5,252 per year)	$309,868
	Placed in the Georgia Retardation Center for lifetime (till 65 @ $12,118 per year)	$714,962
	Based on per diem costs FY 70.	
II.	Mildly retarded, lives at home, becomes independent	
	Preschool, 2 years ($1,000 per year)	$ 2,000
	School, 5 - 18, EMR ($700 per year)	9,100
	Transitional Workshop, 18 months ($1,600 per year)	2,400
		$ 13,500
III.	Mildly retarded without suitable homes, in small group homes	
	Community Services	$ 13,500
	Boarding Home, 6 - 16 ($2,500 per year)	25,000
	16 - 18 ($1,700 per year)	3,400
	Hostel, 18 - 20 ($1,700 per year)	3,400
		$ 45,300
IV.	Moderately retarded with home, community services	
	Preschool day training, 4 - 6 ($1,600 per year)	$ 3,200
	TMR class, 6 - 19 ($1,200 per year)	15,600
	Sheltered workshop and extended employment, 20 - 26, ($1,300 per year)	58,500
		77,300
	Group homes from 35 - 65 ($2,500 per year)	75,000
		$152,300
V.	Moderately retarded without suitable home	
	Community Services	$ 77,300
	Group home, 6 - 65 ($2,500 per year)	147,500
		$224,800
VI.	Severely retarded at home	
	Day training and work activity, 4 - 65 ($1,600 per year)	$ 97,600
	Group home, 35 - 65 ($2,500 per year)	75,000
		$172,600
VII.	Severely retarded in community	
	Community services	$ 97,600
	Group home, 6 - 65 ($2,500 per year)	147,500
		$245,100